



2018

# New Mexico Crisis Standards of Care Plan



NEW MEXICO  
DEPARTMENT OF  
**HEALTH**

# The New Mexico Crisis Standards of Care Plan



The New Mexico Department of Health worked with Public Health, Emergency Management, First Responders, Healthcare, Legal, and other partners to create the New Mexico Crisis Standards of Care (CSC) Plan.

Ethical considerations and principles have played a key role throughout the course of this initiative. Stewardship of resources, duty to care, soundness, fairness, reciprocity, proportionality, transparency, and accountability are the guiding ethical elements of this plan. This foundation has been integrated into public health and emergency response principles to establish this common framework.



### Approval and Implementation

The New Mexico Department of Health All-Hazards Emergency Operations Plan (EOP) **Functional Annex #19 : Crisis Standards of Care Plan** assures development of incident-specific priorities and guidance for the delivery of healthcare, including use of potentially scarce medical resources, depending on the scope and nature of the emergency or disaster by activating the Medical Advisory Team (MAT), select individuals/group comprising of subject matter experts (SMEs) to recommend and provide guidance related to policy, procedures, and potential participation in the State Emergency Operation Center (SEOC). This plan will assist in the management and coordination of DOH resources and personnel during periods of public health emergencies, disasters or events. Planning teams, comprised of subject matter experts, planners and representatives of stakeholder organizations contributed to this Plan.

- This plan is based on the NMDOH All-Hazard Emergency Operations Plan (EOP) and incorporates guidance from the U.S. Department of Health and Human Services (HHS), Centers for Disease Control and Prevention (CDC), Office of the Assistant Secretary for Preparedness and Response (ASPR), U.S. Department of Homeland Security (DHS) and Federal Emergency Management Agency (FEMA). It also builds on lessons learned from planned events, trainings, exercises, disasters, and emergencies, and is aligned with the State of NM All-Hazards EOP in accordance with all state and local law and ordinances.

The Emergency Operations Annex Template follows the plan format established in the Federal Emergency Management Agency's (FEMA) *Comprehensive Preparedness Guide (CPG) 101: Developing and Maintaining State, Territorial, Tribal, and Local Government Emergency Plans*, March 2009

I hereby endorse and approve this updated Crisis Standards of Care Plan effective immediately for the delivery of the incident specific priorities and guidance for the State of New Mexico during times of crisis.

We recognize that this is an evolving plan, as more information and literature reviews are made available about crisis standards of care the plan may evolve. It is also understood that in the event of a public health crisis, this plan may be activated in part or in whole as a standalone guidance.

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Date Effective

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# Table of Contents

<b>Introduction</b> .....	<b>8</b>
<b>Background</b> .....	<b>9</b>
<b>Purpose, Scope, Situation Overview, and Other Assumptions</b> .....	<b>11</b>
<b>Figure 1: New Mexico Healthcare Coalition Map</b> .....	<b>14</b>
<b>Figure 2: Public Health Division State Regions</b> .....	<b>15</b>
<b>Figure 3: New Mexico EMS Regions</b> .....	<b>16</b>
<b>Figure 4 Tribal Lands</b> .....	<b>17</b>
<b>Table 1 Comparison of Capabilities for HPP, PHEP, and FEMA</b> .....	<b>21</b>
<b>Table 2: Allocation of Resources along Care Capability Continuum</b> .....	<b>22</b>
<b>Statewide Concept of Operations</b> .....	<b>25</b>
<b>Figure 5: New Mexico Crisis Standards of Care (CSC) Activation Process</b> .....	<b>27</b>
<b>Figure 6: New Mexico Crisis Standards of Care (CSC) Activation Process</b> .....	<b>28</b>
<b>Clinical Concept of Operations</b> .....	<b>31</b>
<b>Figure 7: Implementation of the Surge Response Framework: Conventional, Contingency, and Crisis Response Cycle</b> .....	<b>31</b>
<b>Table 3: Key Terms used in START and JumpStart triage</b> .....	<b>33</b>
<b>Table 4: CSC Criteria for ICU Admission</b> .....	<b>35</b>
<b>Table 5: SOFA Based Triage for ICU Admission Priority</b> .....	<b>35</b>
<b>Access and Functional Needs</b> .....	<b>38</b>
<b>Out-of-Hospital Care Providers</b> .....	<b>40</b>
<b>Alternate Care Systems</b> .....	<b>42</b>
<b>Fatality Management</b> .....	<b>46</b>
<b>Pediatrics</b> .....	<b>47</b>
<b>Palliative Care and Comfort Care</b> .....	<b>49</b>
<b>Behavioral Health</b> .....	<b>51</b>
<b>Direction, Control &amp; Coordination for CSC Senior Leadership</b> .....	<b>55</b>
<b>Information Collection, Analysis and Dissemination</b> .....	<b>55</b>
<b>Legal Considerations</b> .....	<b>56</b>
<b>Figure 8: The interplay between ethical processes and ethical values</b> .....	<b>58</b>
<b>Statewide CSC Deactivation</b> .....	<b>60</b>
<b>ATTACHMENT 1.</b> .....	<b>61</b>
<b>ATTACHMENT 2.</b> .....	<b>70</b>
<b>ATTACHMENT 3.</b> .....	<b>71</b>



**ATTACHMENT 4** ..... 74  
**APPENDIX A** ..... 77  
**Appendix B** ..... 85



## Crisis Standards of Care

### An Introduction





## Introduction

The New Mexico Department of Health Epidemiology and Response Division, (NMDOH ERD) in collaboration with numerous partners including emergency managers, first responders, healthcare personnel and systems, legal representatives, and public health professionals, to create this Crisis Standards of Care (CSC) Plan for New Mexico.

This ongoing collaborative project will include strategic planning sessions, interagency workgroups, and a public engagement campaign.

This ethical foundation has been aligned with public health and emergency response principles to establish a common framework for the state CSC.

Based on the State All-Hazard Emergency Operations Plan (State EOP) that is promulgated by the Governor with concurrence from participating state agencies, Emergency Support Function (ESF) #8 (annex to the State EOP) describes Public Health and Medical Services, and is further defined in more detail in the New Mexico Department of Health All-Hazard Emergency Operations Plan (DOH EOP), which provides the plan for the response to public health emergencies, disasters and events. The DOH EOP sets forth lines of authority, responsibility and organizational relationships and shows how response actions are coordinated within DOH and with federal, state, tribal and local partners.

In alignment with these plans, New Mexico Department of Health will assure development of incident-specific priorities and guidance for the delivery of healthcare, including use of potentially scarce medical resources, depending on the scope and nature of the emergency or disaster by activating the **Medical Advisory Team (MAT)**, a select group of Subject Matter Experts (SME's) who will make recommendations regarding CSC based on the event.

This guidance may address:

- Triage for emergency medical services (EMS)
- Primary, secondary, and tertiary triage for healthcare facilities
- Expanded scopes of practice, as approved by regulatory authorities
- Priorities for medical resources including space, staff, and supplies
- Considerations for healthcare access points, including hospitals out-of- hospital facilities and alternate care sites

## Background

The Institute of Medicine defined “Crisis Standard of Care” (CSC) to be a “substantial change in the usual health care operations and the level of care it is possible to deliver... justified by specific circumstances... and formally declared by a state government in recognition that crisis operations will be in effect for a sustained period.” Among various terms used in different titles for this definition, the terms “standard” and “altered” are somewhat controversial, since there are an infinite number of catastrophic types and severities of disasters which may impact any given locality. Many such events are also unprecedented and have no standard approach.

<http://www.acphd.org/media/330265/crisis%20standards%20of%20care%20toolkit.pdf>

A pandemic or catastrophic emergency may strain medical and aligned resources and thereby require a shift in care from that which was previously focused on the individual patient to that which is focused on doing the most good for the greatest number.

Healthcare resources include, but are not limited to, personnel, supplies, hospital beds, space, medications, and other treatment-related resources (e.g., clinical laboratory services). Rather than doing everything possible to try to save every life, in an emergency, it may be necessary to allocate scarce resources to save as many lives as possible.

“Crisis Care” is what a prudent Healthcare Provider would do with scarce resources at hand; it does not imply substandard care would be provided. Ethical and emotional issues will arise from a need to promote public health priorities over level of care provided to individuals.

Goals of those providing guidance to communities dealing with a catastrophic emergency will be to:

- Minimize death and serious illness by distributing finite resources to those who have the greatest opportunity to benefit
- Maximize appropriate care for the largest number of individuals
- Maximize care that some of the public can provide to itself through education and other messages
- Delineate which healthcare facilities should provide what level of care based on the capacities and capabilities of the facility
- Provide a legal framework for developing triage decisions
- Engage the public and build trust in the community by being inclusive

The ongoing development and maintenance of this CSC plan will include participants from the public health, healthcare, legal, ethical, and emergency management disciplines. During the initial planning phase, a CSC planning committee was convened to build consensus, establish a common awareness of what crisis care means for New Mexico, and oversee the development of statewide CSC.

Three workgroups were established to facilitate the planning process:

- (1) Clinical Workgroup
- (2) Legal/Ethics Workgroup
- (3) Emergency Medical Systems (EMS) Workgroup

Each group met multiple times to consider issues, research best practices, literature review and make recommendations for content of the Plan.

- The Clinical Workgroup began to establish guidelines for multiple types of triage and expanded scopes of practice
- The Legal/Ethics Workgroup evaluated regulatory, statutory, and bioethical issues (e.g., scopes of practice, duty to care, code of ethics)
- The EMS Workgroup assessed patient transport and clinical issues that would impact EMS providers

This New Mexico CSC project is consistent with the U.S. Department of Health and Human Services (HHS), Office of the Assistant Secretary for Preparedness and Response (ASPR), Office of Preparedness and Emergency Operations (OPEO), Division of National Healthcare Preparedness Programs (NHPP) HPP Cooperative Agreement Catalog of Federal Domestic Assistance (CFDA) number 93.889 and National Guidelines from the Institute of Medicine. The New Mexico CSC Project will require ongoing comprehensive planning efforts undertaken by multi-disciplinary Teams statewide. The CSC Planning Committee identified mission and values for the project, as well as potential objectives for the workgroups. This was designed to facilitate a planning process that would address the needs and expectations of a diverse set of stakeholders.

## **Desired Future State**

Develop and implement a compassionate and ethically-based healthcare response for catastrophic disasters, using CSC in collaboration with key stakeholders.

## **Mission**

Provide a response and recovery framework for catastrophic disasters, enabling optimal community resilience across the healthcare systems.

## **Values**

- **Health Status:** Assure that maximizing the health status of all communities and population will be at the forefront of decision-making
- **Transparency:** Provide open, honest, factual and timely communication and information sharing.
- **Consistency:** Implement processes and procedures across the continuum of care, applying the same approach to achieve optimal community health
- **Fairness:** Respect and recognize the dignity of all populations to include the Access and Functional Needs populations when providing healthcare across the continuum of care.
- **Accountability:** Take responsibility for actions, complete work assignments, and follow through on requests and communications.
- **Resilience:** Provide for the recovery of emotional, spiritual, intellectual and behavioral health needs, while facilitating the well-being of the community.
- **Evidence-Based:** Formulate decisions based on evidence (when available), facts and processes to promote optimal community health.

## Duty to Care

Duty to care for patients always is the obligation of health care professionals. This obligation requires that the patient-provider relationship be maintained always – patients are not abandoned. In an extreme disaster with scarce resources, it is understood that all patients may not receive all levels of care available in normal times, but all patients will receive some level of available care.

## Purpose, Scope, Situation Overview, and Other Assumptions

### Purpose

The purpose of this plan is to provide clear and consistent guidance for allocating scarce healthcare resources during a catastrophic disaster. This plan builds on best practice CSC planning initiatives, strong interdisciplinary relationships, and lessons learned at the national, state and local levels. This plan was developed using the **Institute of Medicine (IOM) report *Crisis Standards of Care: A Systems Framework for Catastrophic Disaster Response* (2012).**

<http://www.nationalacademies.org/hmd/Reports/2012/Crisis-Standards-of-Care-A-Systems-Framework-for-Catastrophic-Disaster-Response.aspx>

This report outlines five principles that should guide CSC planning across the nation, including the following:

- A strong ethical grounding based in transparency, consistency, proportionality, and accountability
- Integrated and ongoing community and provider engagement, education, and communication
- The necessary legal authority and legal environment in which CSC can be ethically and optimally implemented
- Clear indicators, tactics, and lines of responsibility
- Evidence-based clinical processes and operations

### Authority and Policy

The New Mexico Department of Health All Hazards Emergency Operations Plan establishes coordinating structures, processes, protocols and responsibilities to integrate statutory and policy authorities with Federal, State, Tribal governments and local agencies. Several Federal and State statutory authorities and policies provide the basis for the New Mexico Department of Health All Hazards Emergency Operations Plan. In alignment with the all-hazard Plan, the CSC Plan uses the authority and policies listed below as a foundation to provide a comprehensive approach to Crisis Standards of Care management in New Mexico.

The Crisis Standards of Care Plan does not alter the existing authorities of Federal, State, or local agencies, or Tribal governments. The Plan provides a collective interoperability framework for emergency response action to include response, and recovery activities during and after an emergency incident response requiring activation of Crisis Standards of Care.

This CSC Plan and its components may be used in conjunction with other Federal, State, Tribal and local incident management and All Hazards Emergency Operations Plans developed under these and other authorities as well as Memorandums of Understandings (MOU's) or Memorandums of Agreement (MOA's) among various Federal and State agencies.

- Department of Health Act, Sections 9-7-1, et seq., NMSA 1978
- State Civil Emergency Preparedness Act, Sections 12-10-1, et seq., NMSA 1978

- Public Health Emergency Response Act, Sections 12-10A-1, et seq., 3NMSA 1978
- Public Health Emergency Response Act, Section 12-10A-6.C, NMSA 1978
- State Civil Emergency Preparedness Act, Sections 12-10-11 through 13, NMSA 1978
- Public Health Act, Sections 24-1-1, et seq., NMSA 1978
- Emergency Medical Systems Fund Act, Sections 24-10A-2, et seq., NMSA 1978
- Emergency Medical Systems Act, Sections 24-10B-1, et seq., NMSA 1978
- Medical Investigations, Sections 24-11-1 to 24-11-10, NMSA 1978
- Disposition of Dead Bodies, Sections 24-12-1 to 24-12A-3, NMSA 1978
- Burial of Indigents, Sections 24-13 -1, et seq., NMSA 1978
- Annex 5, ESF 6 Public Health, Medical & Mortuary.
- Robert T. Stafford Disaster Relief and Emergency Assistance Act, as amended by Public Law 106-390, October 30, 2000

## Scope

The Crisis Standards of Care Plan is a guidance document defining the roles and responsibilities of DOH personnel providing a scalable, flexible, adaptable and coordinated response that aligns structures, actions and tasks within the DOH. The CSC Plan serves as a Functional Annex to the DOH's EOP.

This Plan contains procedures to guide in the activation, operations and deactivating the CSC Plan for New Mexico to include: triage guidelines and considerations for healthcare facilities; implement strategies and tactics for using and allocating scarce healthcare resources. Consistent with the Incident Command System (ICS), the scope of CSC MAT activities will be determined by the nature, severity, and scale of the disaster.

This plan is intended to work in concert with other New Mexico State-level Emergency Response Plans such as state and local Alternate Care Site/System Plans, Medical Countermeasure Plans (including mass prophylaxis and mass vaccination), Medical Materiel Management and Distribution Plans, and Medical Surge Plans. This plan does not fully address CSC implementation at the regional, local, or Healthcare Facility levels

This Plan is a guidance document providing a framework that may need to be modified depending on the specific nature of the emergency.

CSC will also need to be coordinated by state-designated Healthcare Coalitions, Counties, and Healthcare Facilities. During a catastrophic disaster requiring statewide CSC activation, Medical Surge, Fatality Plans and Response Plans at the local and facility levels will be integrated into the comprehensive, statewide response.



## General Principles of Crisis Care Response

In addition to the ethical framework, several key concepts listed below shaped the guidance for the development process of the Crisis Standards of Care Plan:

**1) Promote fairness and consistency in health care during a crisis**

If we agree on care strategies and share them broadly before a crisis occurs, healthcare workers will have a standard to guide their actions. Consistent implementation of this guidance ensures that resources are allocated using the same priorities and principles.

- Duty to care
- Duty to steward resources
- Duty to plan
- Distributive justice
- Transparency

**2) Ensure an open process in both development and use of the guidance**

The broader healthcare community and the public need to be aware of and involved in crisis care planning. Strategies used to decide who receives what kind of care in a crisis need to be available to the public.

**3) Recognize the important differences in the medical needs of children and adults, to include the differences the care they receive**

It is essential that crisis care guidance addresses the special needs of children and others with special healthcare needs.

**4) Ensure availability of factual, current information about any crisis**

Coordination between agencies, healthcare system, media, and the public are needed to provide accessible, accurate, and useful information. In a crisis, it should be made clear when people need to seek medical evaluation, and when they can be cared for at home or alternative sites.

**5) Employ strategies beyond those used in routine care only when and to the degree required by the crisis at hand**

Non-routine strategies should be initiated and or continued only if the situation warrants them. Coordination is vital for effective healthcare crisis response. Communication among health systems, between healthcare providers--hospital and non-hospital based--and across jurisdictions enable a community to use resources more efficiently.

A regional approach to resource management may be required to coordinate activities across the multiple jurisdictions and entities involved in surge response. NMDOH has systems in place to track availability of hospital beds, critical care equipment, and other key resources. These systems will promote effective use of resources when healthcare facilities and dedicated personnel meet their responsibility to update the information related to facility status, reportable conditions, potential or actual hazards, and other relevant and requested information. Regular reporting to these systems during a public health crisis would help ensure that these resources can be used most effectively.



## Situation Overview

New Mexico has developed Regional Healthcare Coalitions across the state as follows:

**Region 1 – Northwest Area**  
**Region 2 – Southwest Area**

**Region 3 – Southeast Area**  
**ARCH-P - Albuquerque**

Figure 1: New Mexico Healthcare Coalition Map

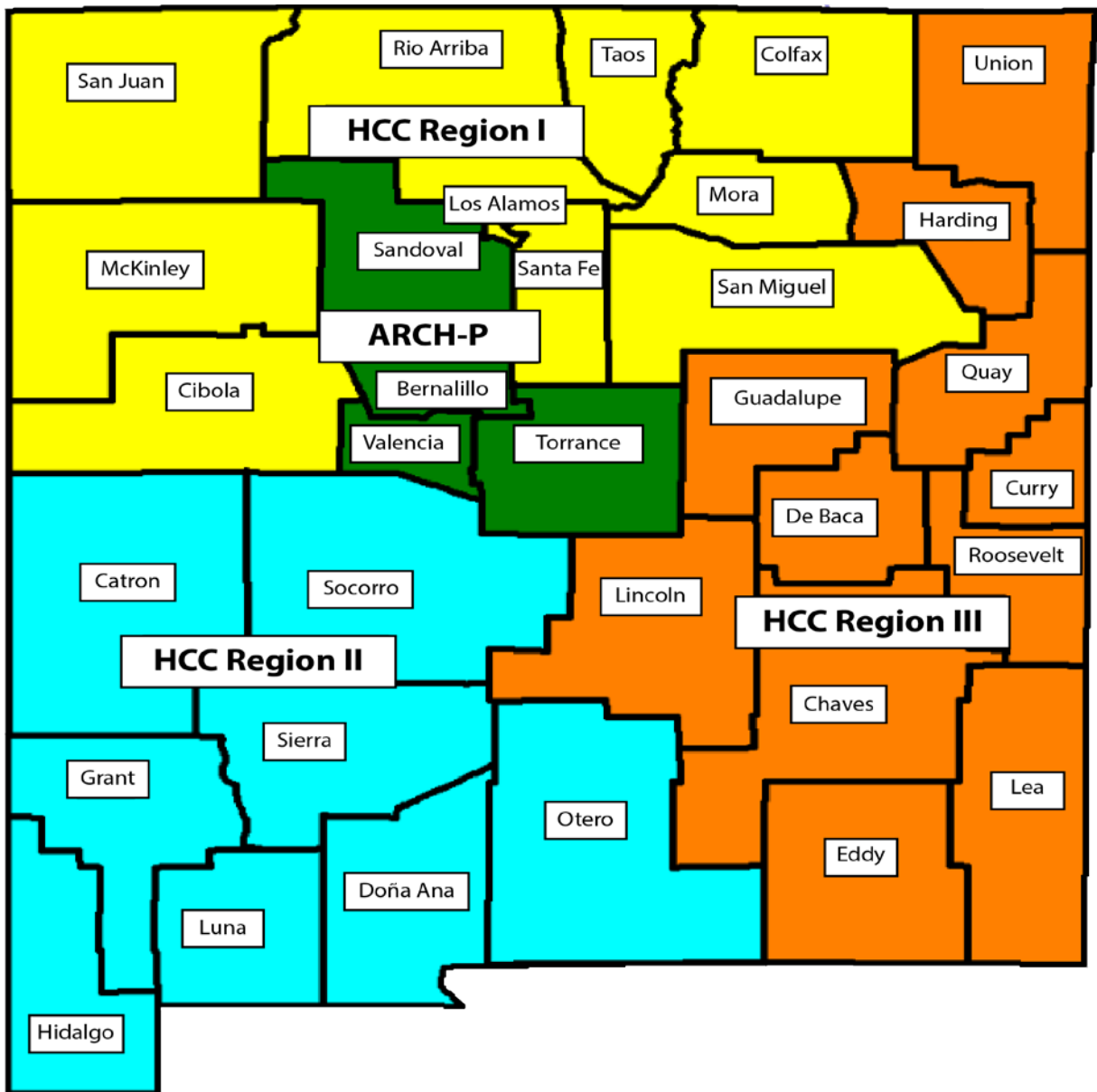


Figure 2: Public Health Division State Regions

Northwest Region	San Juan, McKinley, Cibola, Bernalillo, Sandoval, Torrance, Valencia
Southwest Region	Catron, Socorro, Grant, Sierra, Hidalgo, Luna, Doña Ana, Otero
Northeast Region	Rio Arriba, Taos, Colfax, Union, Los Alamos, Santa Fe, Mora, San Miguel, Guadalupe, Harding
Southeast Region	Quay, DeBaca, Curry, Lincoln, Roosevelt, Chaves, Eddy, Lea

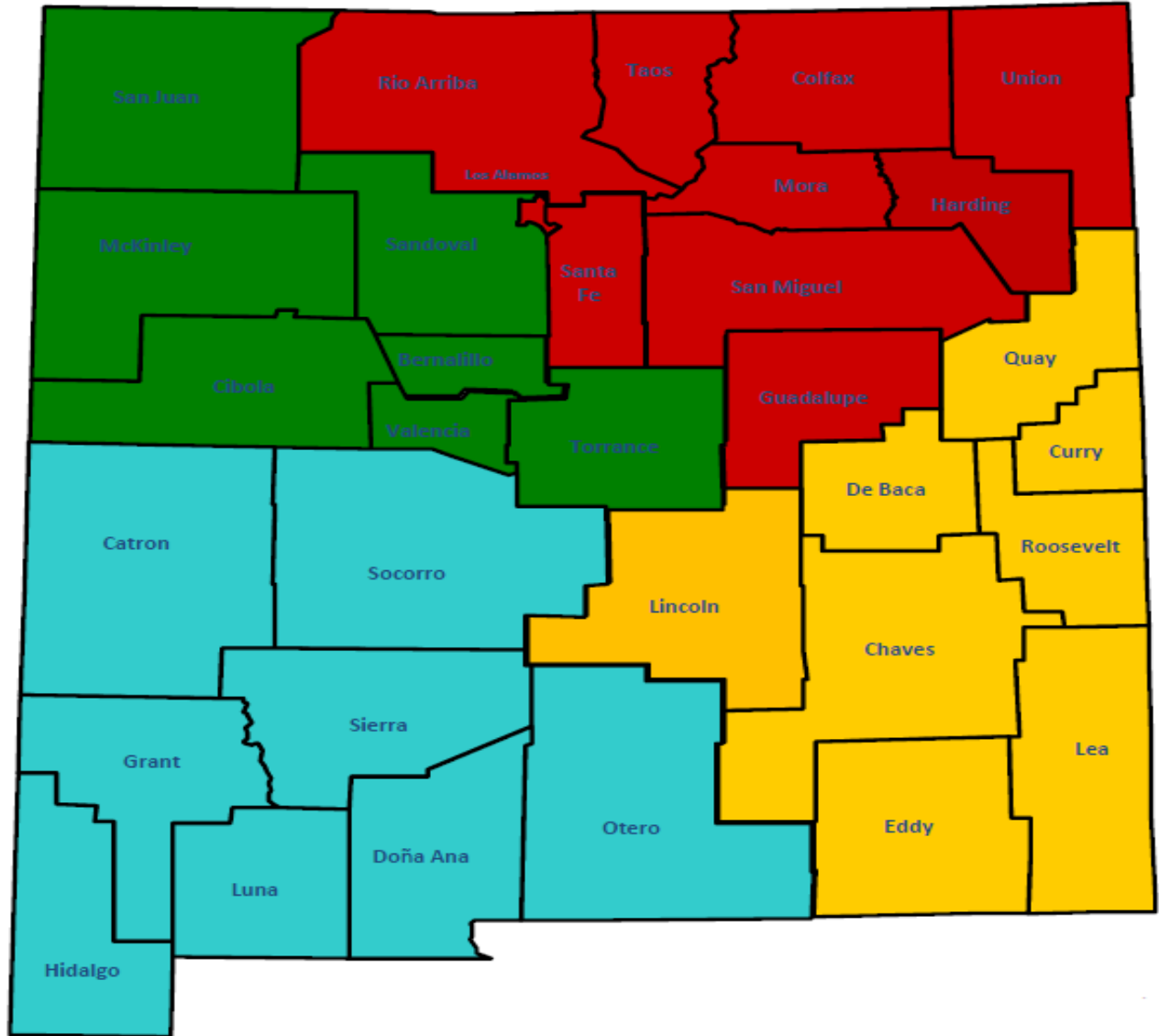


Figure 3: New Mexico EMS Regions

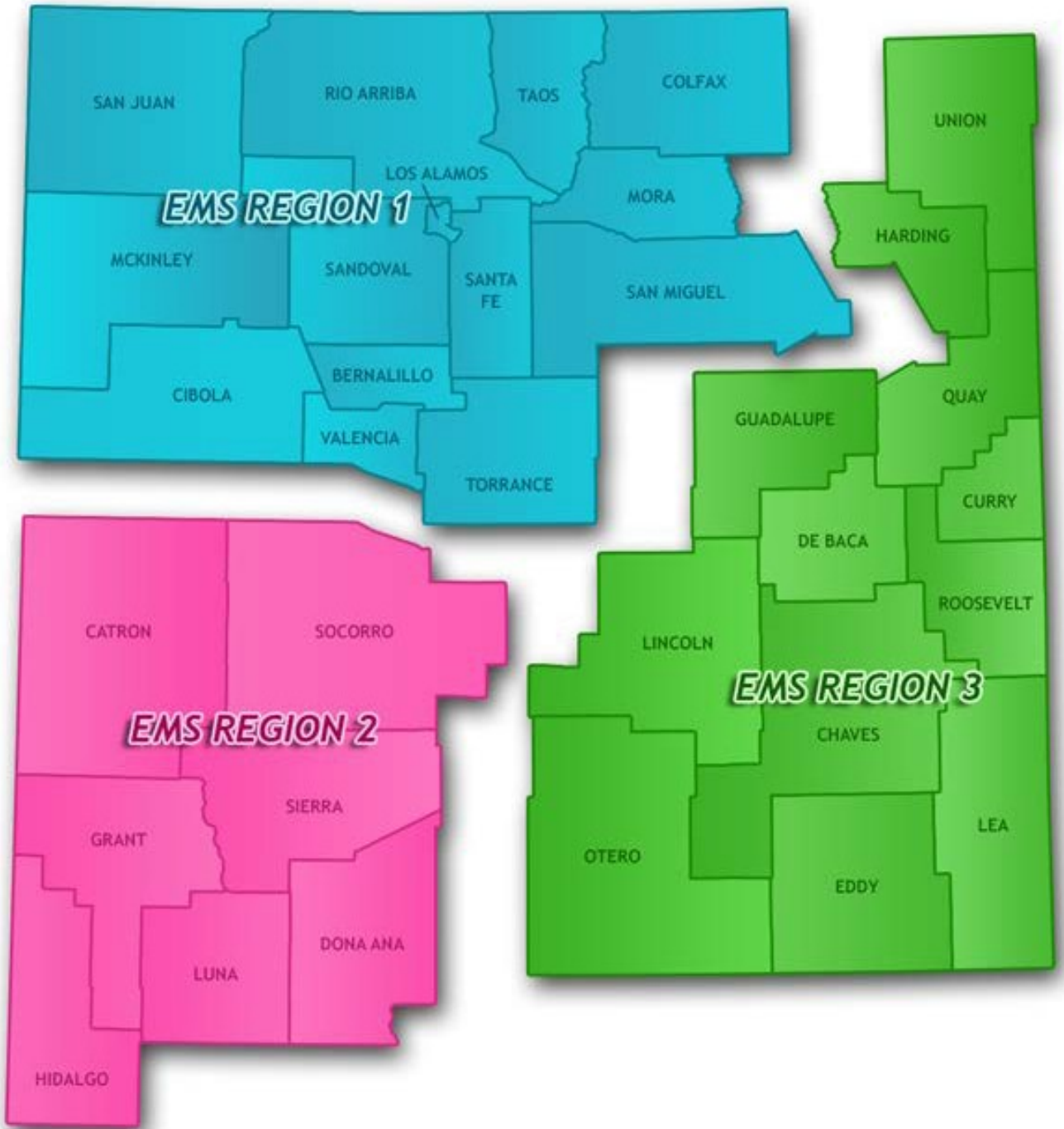
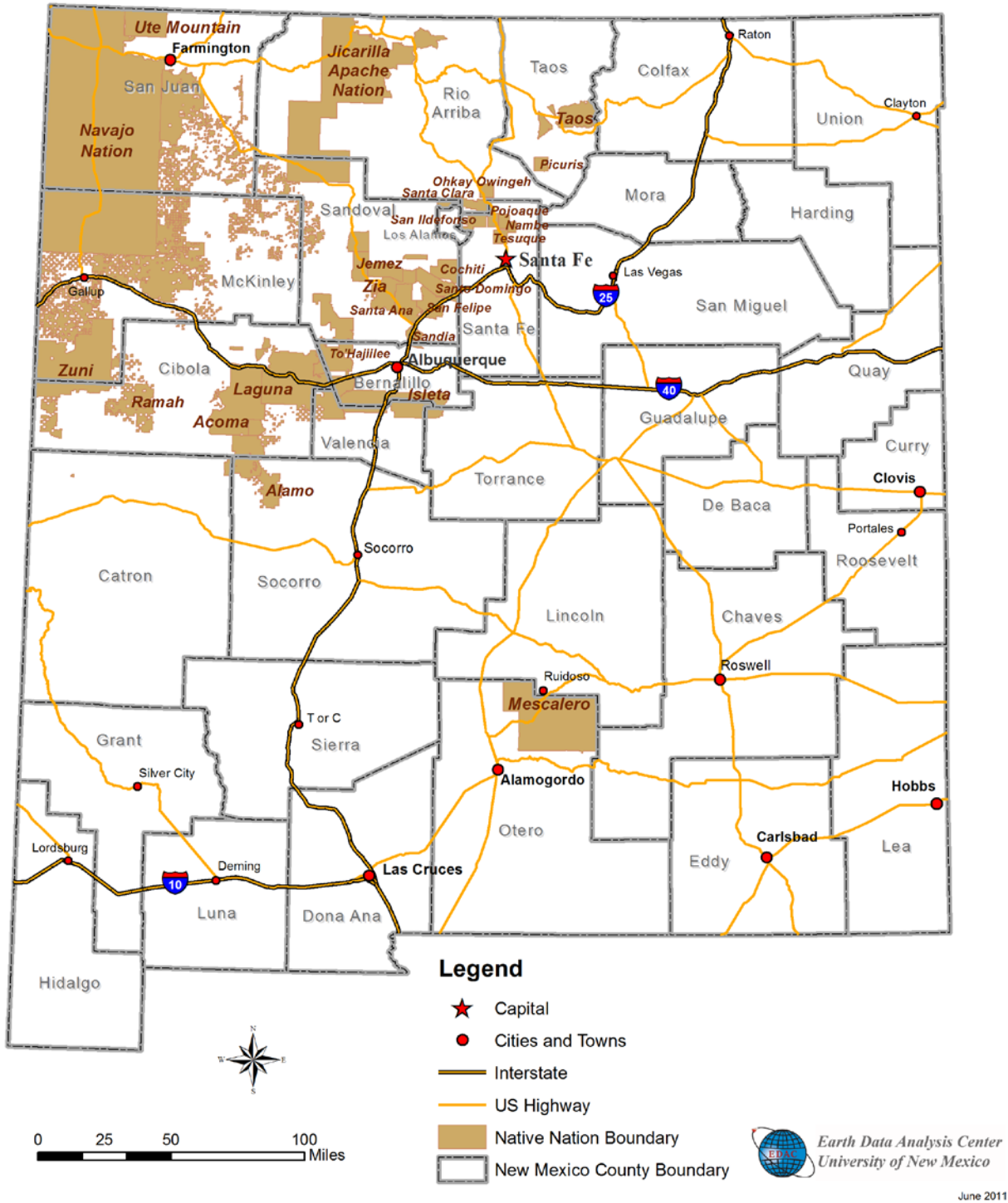


Figure 4: Tribal Lands



## Hazards

Numerous known and unforeseen hazards could prompt the activation of CSC in New Mexico; these include chemical, biological, radiological, nuclear, and explosive threats (CBRNE), as well as natural disasters such as floods, wildfires, earthquakes, or severe weather. Additional hazards could include man-made disasters such as technological failures, accidents, terrorist attacks, civil unrest, or acts of war. Hazard analysis is the basis for both emergency operations planning and mitigation planning. For emergency operations planning purposes the process identifies which hazards merit special attention, what actions must be planned for, and what resources are likely to be needed. The DOH CSC Plan is prepared using an all-hazard approach suitable for use in any situation. The DOH Threat and Hazard Identification and Risk Assessment Functional Annex includes hazard identification, hazard profiles, vulnerability assessment, and loss estimation related specifically to public health emergencies, disasters and events.

## Capability Assessment

A capabilities-based, planning approach was used to guide this planning initiative. Federal Emergency Management Agency (FEMA) defines capabilities-based planning as “planning under uncertainty to provide capabilities suitable for a wide range of threats and hazards while working within an economic framework that necessitates prioritization and choice. Capabilities-based planning addresses uncertainty by analyzing a wide range of scenarios to identify required capabilities.”

The DOH is responsible for statewide development of the Public Health Preparedness Capabilities defined by the Centers for Disease Control and Prevention (CDC) and the Healthcare Preparedness Capabilities defined by the Assistant Secretary for Preparedness and Response (ASPR). This capability development is accomplished through planning, organizing, equipping, training, exercising, evaluating and improving activities with preparedness partners throughout the State.

The DOH has facilities and public health offices in each of the four Public Health Regions and collaborates with local jurisdictions and the 23 Indian Nations, Tribes or Pueblos within New Mexico. Coordination of an emergency response is conducted through the Secretary of Health, Epidemiology and Response Division, Bureau of Health Emergency Management, Public Health Division and Regional Public Health Offices with local jurisdictions, Scientific Laboratory Division and healthcare facilities throughout the state. The DOH continually monitors and collects health information from a variety of health surveillance systems throughout the state. In addition, the DOH maintains, staffs and operates its Department Operations Center (DOC). The DOH DOC operates using NIMS principles and an ICS structure. The DOH maintains agreements with federal, state, local, tribal and private sector vendors to support the Strategic National Stockpile (SNS) medical countermeasures (MCM) and pharmaceutical resource distribution statewide in the event of an emergency or disaster.

**\*CDC Capability 10: Medical Surge** *Medical surge is the ability to provide adequate medical evaluation and care during events that exceed the limits of the normal medical infrastructure of an affected community. It encompasses the ability of the healthcare system to survive a hazard impact and maintain or rapidly recover operations that were compromised.*

**The Institute of Medicine (IOM) report identifies “five pillars” of CSC:**

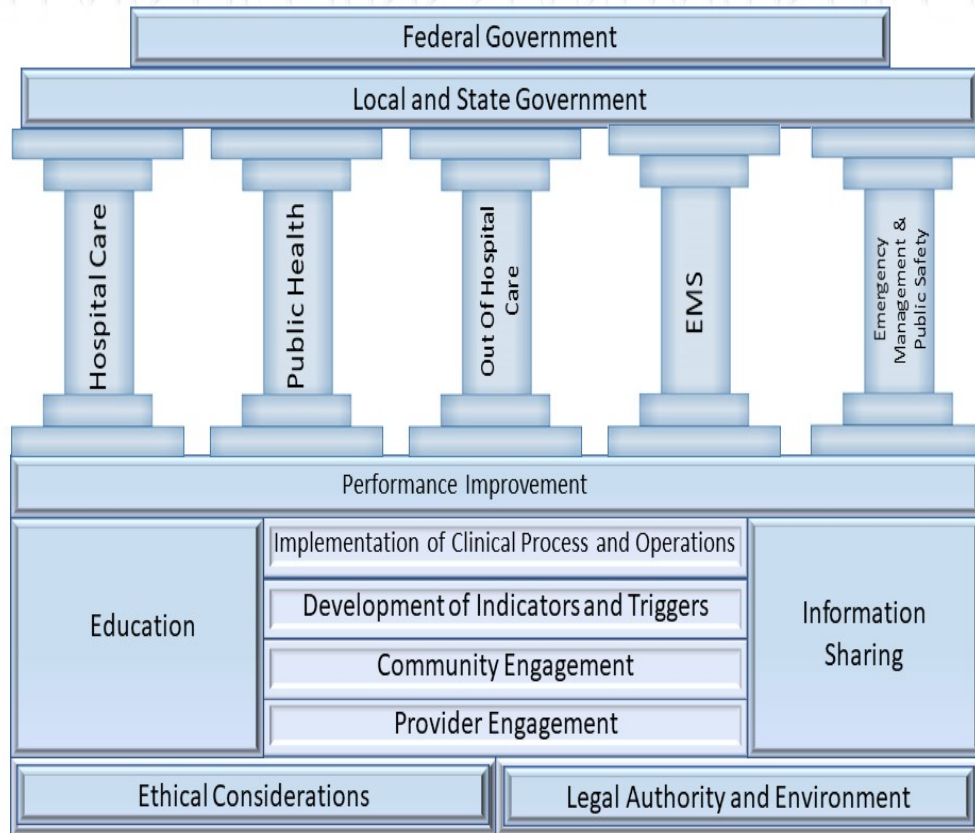
- (1) Hospital
- (2) Public Health
- (3) Out-of-hospital Care
- (4) Emergency Medical Services (EMS)
- (5) Emergency Management and Public Safety

Coordinating these five pillars requires integrating standards and systems from a variety of disciplines. These standards, or sets of capabilities, provide the foundation for integrating the five pillars into a single system, allowing for capabilities-based planning.

Three sets of capabilities were used to develop this plan:

- (1) Healthcare Preparedness Capabilities
- (2) Public Health Preparedness Capabilities
- (3) FEMA Core Capabilities

# 5 PILLARS OF CRISIS STANDARDS OF CARE





In January 2012, the US Department of Health and Human Services (HHS), Office of the Assistant Secretary for Preparedness and Response (ASPR) published the **Healthcare Preparedness Capabilities: National Standards for Healthcare System Preparedness**.

<http://www.phe.gov/preparedness/planning/hpp/reports/documents/capabilities.pdf>

These capabilities provide unified program evaluation standards for healthcare organizations and response entities (e.g., state/local public health, emergency management, licensing) involved with the ASPR's Hospital Preparedness Program (HPP).

These healthcare preparedness capabilities correspond directly to eight of the fifteen Healthcare Preparedness Capabilities, thereby allowing public health and healthcare system planners to collaborate within a common framework.

In March 2011, the Centers for Disease Control and Prevention (CDC), Division of State and Local Readiness (DSLRL) published the **Public Health Preparedness Capabilities: National Standards for State and Local Planning**. <https://www.cdc.gov/phpr/readiness/capabilities.htm>

It includes 15 capabilities defined as “national standards for public health preparedness capabilities-based planning.” These capabilities are used by state and local Public Health Emergency Preparedness (PHEP) programs to align planning across jurisdictions and response entities, and ultimately “assure safer, more resilient, and better prepared communities.”



## Capability Assessment

An additional set of capabilities central to CSC planning is the Federal Emergency Management Agency's (FEMA) Core Capabilities. This system of 31 capabilities provides a planning framework for response entities, including emergency management, public safety, public works, schools, and others not directly involved in public health or healthcare. <https://www.fema.gov/core-capabilities>

**Table 1: Comparison of Capabilities for HPP, PHEP, and FEMA**

<b>Healthcare Preparedness Capabilities (HHS, ASPR 2012)</b>	<b>Public Health Preparedness Capabilities (CDC, DSLR 2011)</b>	<b>FEMA Core Capabilities (FEMA 2012)</b>
<ul style="list-style-type: none"> <li>• Healthcare System Preparedness</li> <li>• Healthcare System Recovery</li> <li>• Emergency Operations Coordination</li> <li>• Fatality Management</li> <li>• Information Sharing</li> <li>• Medical Surge</li> <li>• Responder Safety &amp; Health</li> <li>• Volunteer Management</li> </ul>	<ul style="list-style-type: none"> <li>• Community Preparedness</li> <li>• Community Recovery</li> <li>• Emergency Operations Coordination</li> <li>• Emergency Public Info. &amp; Warning</li> <li>• Fatality Management</li> <li>• Information Sharing</li> <li>• Mass Care</li> <li>• Medical Countermeasure Dispensing</li> <li>• Medical Material Management &amp; Distribution</li> <li>• Non-Pharmaceutical Interventions</li> <li>• Public Health Laboratory Testing</li> <li>• Public Health Surveillance &amp; Epidemiology Investigation</li> <li>• Responder Health &amp; Safety</li> <li>• Volunteer Management</li> </ul>	<ul style="list-style-type: none"> <li>• Access Control &amp; Identity Verification</li> <li>• Community Resilience</li> <li>• Critical Transportation</li> <li>• Cyber Security</li> <li>• Economic Recovery</li> <li>• Environmental Response/Health Safety</li> <li>• Fatality Management Services</li> <li>• Forensics &amp; Attribution</li> <li>• Health&amp; Social Services</li> <li>• Housing</li> <li>• Infrastructure Systems</li> <li>• Intelligence &amp; Information Sharing</li> <li>• Interdiction &amp; Disruption</li> <li>• Long-term Vulnerability Reduction</li> <li>• Mass Care Services</li> <li>• Search &amp; Rescue Operations</li> <li>• Natural &amp; Cultural Resources</li> <li>• On-scene Security &amp; Protection</li> <li>• Operational Communications</li> <li>• Operational Coordination</li> <li>• Physical Protective Measures</li> <li>• Planning</li> <li>• Public &amp; Private Services &amp; Resources</li> <li>• Public Health &amp; Medical Services</li> <li>• Public Information &amp; Warning</li> <li>• Risk &amp; Disaster Assessment</li> <li>• Risk Management</li> <li>• Screening Search &amp; Detection</li> <li>• Situational Assessment</li> <li>• Supply Chain Integrity &amp; Security</li> <li>• Threats &amp; Hazard Identification</li> </ul>

## Planning Assumptions

Statewide CSC activation will only occur during the most extreme emergencies that, dramatically impacting the healthcare system. A CSC emergency has the following triggers:

- Most or all the community's infrastructure is impacted
- Local officials are unable to perform their usual roles for a period, extending well beyond the initial aftermath of the incident
- Most or all routine community functions are immediately and simultaneously disrupted
- Surrounding communities are similarly affected, and thus there are no regional resources

The care capability continuum includes conventional, contingency, and CSC. In many cases, the activation of CSC will proceed from: conventional, to contingency, and finally to CSC. Sudden onset emergencies (e.g., earthquake, nuclear detonation) may escalate directly to CSC.

*Refer to additional Planning Assumptions in the NM DOH EOP – pg. 14*

Table 2: Allocation of Resources along Care Capability Continuum

<b>Allocation of Resources along Care Capability Continuum</b>			
	<b>Conventional</b>	<b>Contingency</b>	<b>Crisis</b>
<b>SPACE</b>	Usual patient care space fully used	Patient care areas re-purposed (PACU, monitored units of ICU care) *	Facility damaged/unsafe or non-patient care areas (classrooms, etc.) used for patient care
<b>STAFF</b>	Usual staff called in and utilized	Staff extension (brief deferrals of non-emergency service, supervision of broader group of patients, change in responsibilities documentation, etc.)	Trained staff unavailable or unable to adequately care for volume of patients even with extension techniques
<b>SUPPLIES</b>	Cached and usual supplies used	Conservation, adaptation, and substitution of supplies with occasional re-use of select supplies	Critical supplies lacking, possible reallocation of life-sustaining resources
<b>STANDARDS OF CARE</b>	Usual Care	Functionally equivalent care	Crisis Standards of Care
*Note: ICU – Intensive Care Unit; PACU – Post Anesthesia Care Unit Source: (Crisis Standards of Care, IOM, P. 1-41, 2012)			

<https://asprtracie.hhs.gov/technical-resources/63/Crisis-Standards-of-Care>

There are several criteria (i.e., indicators) that must be met for the state to activate CSC. A disaster may occur at an individual hospital or healthcare facility requiring short-term crisis care at that location; however, statewide activation of CSC will only occur during a widespread disaster impacting multiple hospitals/healthcare facilities in a large geographical area or densely populated urban area.

**The following criteria describe a situation that will indicate CSC per the IOM 2012:**

- Resources are unavailable or undeliverable to healthcare facilities
- Similar strategies are invoked by other healthcare delivery systems
- Patient transfer is not possible or feasible, at least in the short term
- Access to medical countermeasures (e.g., vaccine, medications, antidotes, blood products) are limited
- Available local, regional, state, federal resource caches (e.g., equipment, supplies, medications) have been distributed, and no short-term resupply of such stocks is foreseeable
- Multiple healthcare access points within a community or region are impacted

Policies, guidance and CSC operations will reflect this framework when developing strategies to support equitable and just distribution of scarce resources. CSC strategies will involve the integration of local, state, and communities serving access and functional needs in an ongoing capacity, to also consider those persons injured or ill because of the disaster.

## **Planning Strategies**

As defined in this plan, strategies may be employed at any point before the onset of a crisis with the intent of improving response. As with the surge capacity and triage strategies, best practices are considered specific to healthcare and other considerations; however, most are broadly applicable:

- Develop plans to support continuity of critical functions during a crisis.
- Identify potential alternate care sites (e.g., long-term care facilities, veterinary hospitals, surgery centers) with suitable infrastructure to support acute care of ill or injured patients.
- Develop draft requests for Centers for Medicare and Medicaid Services (CMS) to waive specified provisions of the Emergency Medical Treatment and Labor Act (EMTALA) or other federal laws that may present barriers to effective crisis response.
- Develop draft requests to New Mexico licensing boards for waivers in licensing, documentation, and other requirements that may present barriers to effective crisis response.
- Develop/update memoranda of agreement with potential suppliers, alternate care sites, and other healthcare employers to maximize availability of space, staff, and supplies.
- Involve all staff, clinical and non-clinical, in some level of workplace emergency and disaster preparedness, including individual/family preparedness (to allow employees to come to work and/or work non-routine schedules).
- Cross train staff, as practical, to maximize available staffing for critical healthcare functions.
- Plan and carry out periodic exercises to support regional and facility proficiency in implementing key components (e.g., triage and resource allocation) of crisis care response.
- Develop consultation networks for crisis care of children and others with special care needs (e.g., burns, trauma, hazardous exposures).
- Involve clinicians with pediatric and other relevant expertise in crisis care planning.
- Plan with law enforcement to ensure safety of those using health facilities in a crisis.
- Stock sufficient supplies to maintain care for 96 hours.
- Make seismic upgrades to any older masonry or concrete structures in health facilities.
- Prioritizing clinical and non-clinical healthcare personnel, personal protective equipment, relevant vaccines, and other preventive measures to maintain staffing levels

## Concept of Operations

Public Health and Medical Officials at all levels of Government must be prepared to address sudden and unexpected demands for services that may exceed readily available resources during an emergency.



## Statewide Concept of Operations

CSC activation requires the interaction of multiple disciplines across the response community including hospitals, public health, out-of-hospital care providers, emergency management, and public safety. Each of these disciplines operates independently and inter-dependently during routine, non-emergent situations. However, during a disaster response, these groups must operate collectively in a complex, dynamic system. The organization of these various entities into a cohesive response structure is the essence of this CSC plan. CSC activation can occur suddenly, as in the case of an unforeseen terrorist attack, explosion, or abrupt natural disaster (e.g., earthquake), or gradually as in the case of a slowly evolving incident such as a pandemic. In either case, CSC activation and implementation will be guided by this plan.

The exact composition of the NMDOH Leadership Team and **MAT (Medical Advisory Team)** will be incident specific. Depending on the disaster, various configurations of experts across the health, medical, legal, ethical, and emergency management fields will be required to develop priorities for the allocation of scarce resources and issue clinical guidance.

**The NMDOH Leadership Team may include the following standing members:**

- Leadership from the NMDOH
- State EMS Leadership

**The MAT will include the following standing members:**

- Medical Boards
- Healthcare Coalition Leadership
- SME's

***See CSC Reference Guide Book for a list of Job Action Sheets for DOH Leadership and facility-level CSC positions.***

## Department of Health Senior Leadership

Once CSC activation has been approved by the New Mexico Department of Health, representatives from state, public health, healthcare, EMS, emergency management, and public safety will convene, virtually or in person, to activate the CSC MAT, following National Incident Management guidance. Identified NMDOH Leadership will conduct a meeting to identify additional participants, including subject matter experts and others with expertise and experience required to address the specific disaster.

At this point in the activation process, before CSC priorities or clinical guidance have been decided and disseminated, NMDOH staff will notify relevant local, state, and federal agencies of the current situation relative to health and medical considerations. The DOH Leadership Team will work with public information officers to develop public messaging explaining the forthcoming adoption of statewide CSC.



Once the DOH CSC Leadership Team is operational, the pre-identified objectives are defined in keeping with Incident Command System (ICS) principles of scalability and flexibility.

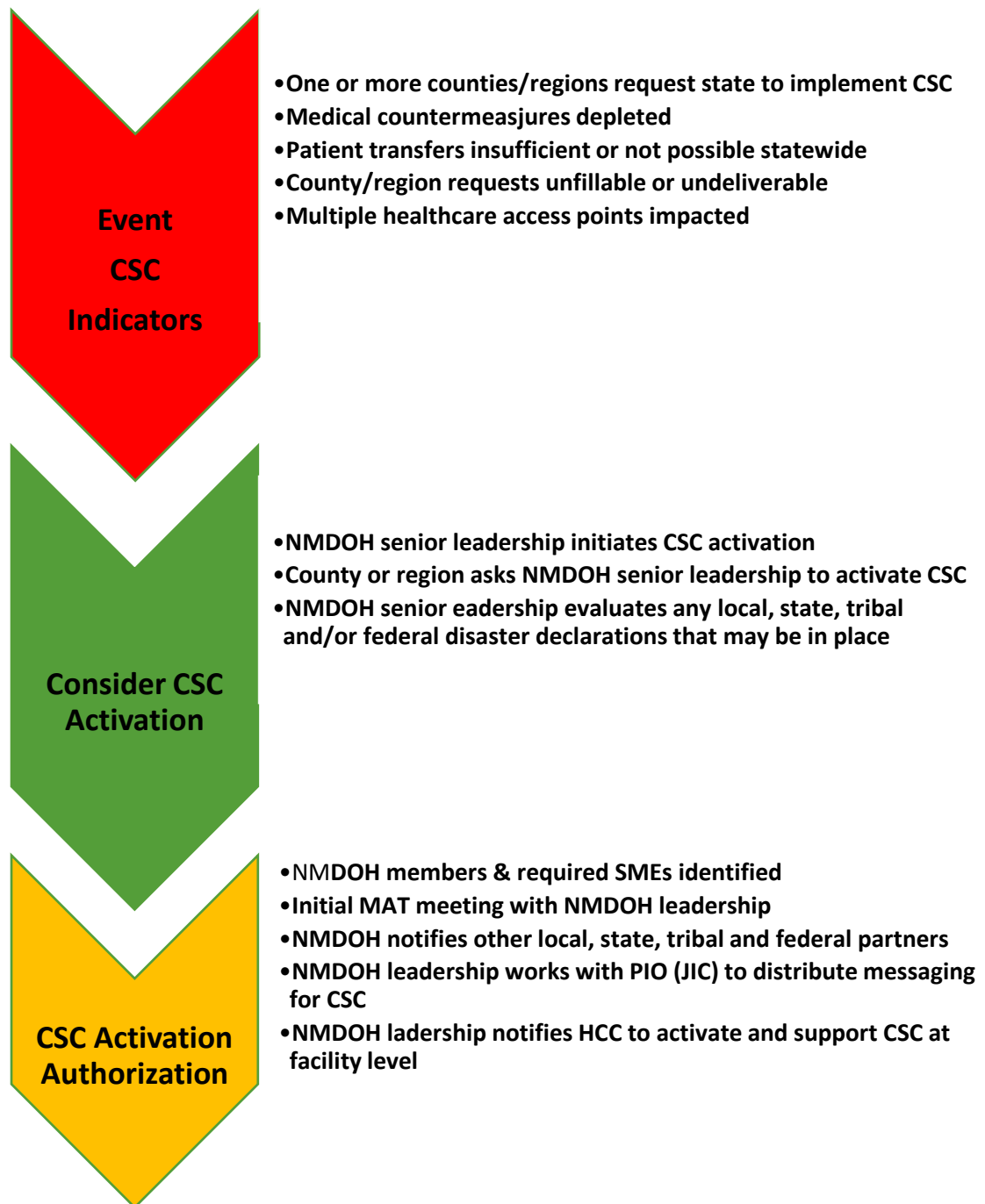
- (1) Establish priorities for allocation of medical resources**
- (2) Establish and disseminate clinical guidance for CSC**
- (3) Develop guidelines for hospitals, out-of-hospital facilities/providers, and alternate care sites**
- (4) Determine need for expanded scopes of practice based on regulatory authority and direction**

During statewide CSC operations, state-designated Healthcare Coalitions may be used to help coordinate CSC implementation with state partners. The purpose of these Coalitions is to assist with the implementation and execution of CSC locally, and at healthcare facility levels.

At the facility level, a Clinical Care Committee (CCC) will oversee implementing statewide priorities and guidance for individual healthcare facilities. The CCC will work under the direction of the hospital or healthcare facility Incident Command (IC). The main purpose of the CCC is to separate the difficult task of triage and allocation of scarce resources from the ongoing responsibility to provide patient care. By separating triage from the act of caring for patients, the healthcare facility will be able to more easily transition from individual care to community-wide, or population-based care.



**Figure 5: New Mexico Crisis Standards of Care (CSC) Activation Process**



<https://www.nap.edu/>

**Figure 6: New Mexico Crisis Standards of Care (CSC) Activation Process**



<https://www.nap.edu/>

## Indicators for CSC Activation

### Continuum of Care



Some disasters may immediately mandate CSC, while other disasters may gradually transition across the continuum of care to CSC. Indicators are designed to assist healthcare and public health officials the ability to assess the need for crisis standards of care during a disaster. Definitions for key CSC activation terms are listed below:

**Indicator:** A measurement, event, or other data that predicts a change in demand for healthcare. This often requires further monitoring, analysis, information sharing, and/or emergency responses.

**Trigger Point:** A decision point based on the availability of resources, requiring adaptations to healthcare delivery along the continuum of care (contingency, conventional, and crisis). (“threshold” and “trigger point” are synonymous)

**CSC Trigger Point:** The point at which the scarcity of resource requires a transition from contingency care to CSC. This is the point at which resource allocation focuses on the community, emphasizing population health rather than individual outcomes.

<https://www.nap.edu/>



# Clinical Concept of Operations

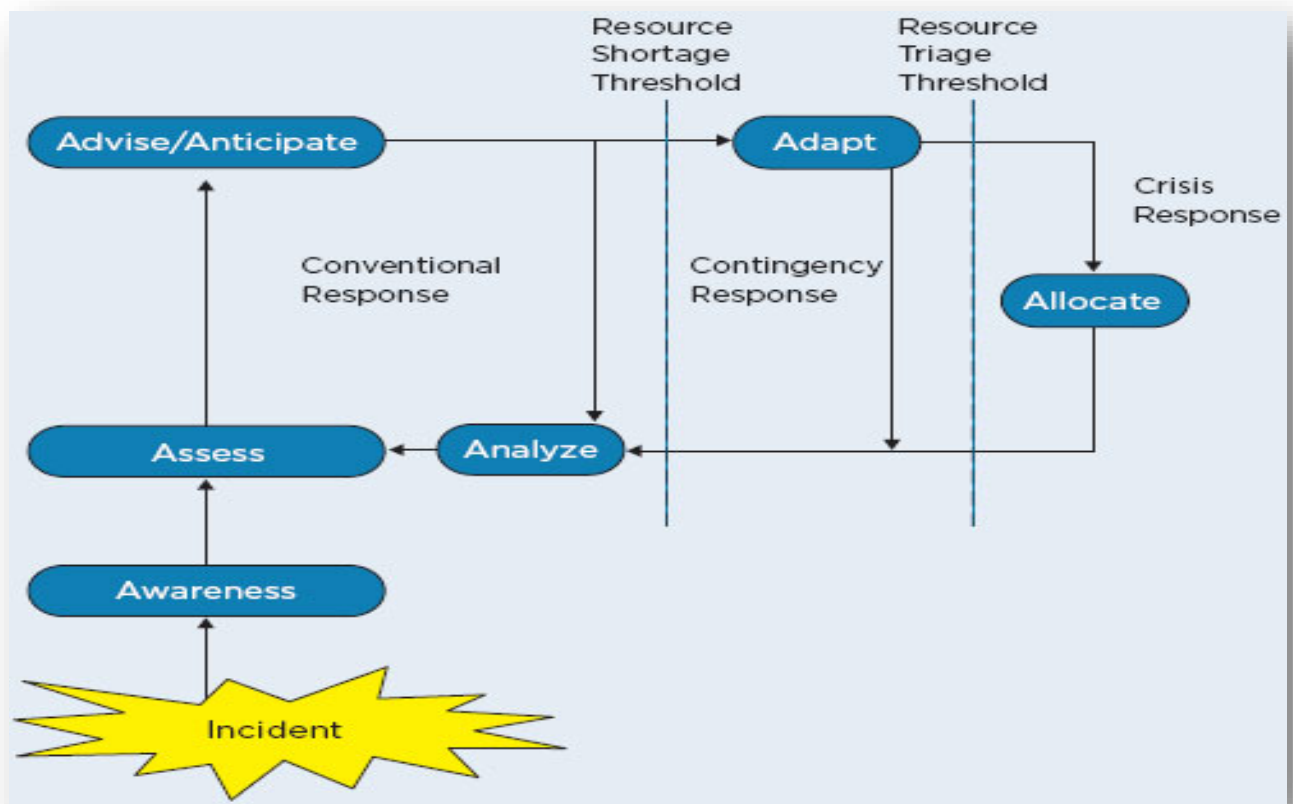


## Clinical Concept of Operations

Clinical concept of operations and response provides considerations and guidance for NMDOH CSC Leadership to consider during an event when Crisis Standards of Care is necessary.

**The following topics are covered in this section:**

- Prehospital and Emergency Medical Services
- Hospital and Acute Care Facilities
- Alternate Care Sites and Systems
- Pediatrics
- Access & Functional Needs
- Palliative and Comfort Care
- Out-of-Hospital Care
- Behavioral Health



**Figure 7: Implementation of the Surge Response Framework: Conventional, Contingency, and Crisis Response Cycle**

After an incident occurs, the priority is to develop situational **Awareness**, and then to **Assess** the situation relative to the available resources. The MAT along with relevant technical experts and/or the clinical care committee (in a proactive response/longer-term incident) **Advises** on strategies and **Anticipates** any resource deficits (and recommends obtaining necessary supplies, staffing, etc.). If a resource is scarce, **Adaptive** strategies (such as conservation, substitution, adaptation, and reuse) should be implemented. In a crisis, a deliberate triage decision to **Allocate**/reallocate resources may be necessary. In all cases, the response and any strategies should be **Analyzed** at regular intervals as part of the disaster response planning cycle, and the elements repeated until the incident concludes. [https://www.annemergmed.com/article/S0196-0644\(11\)00676-7/fulltext](https://www.annemergmed.com/article/S0196-0644(11)00676-7/fulltext)

## The Continuum of Care

### Prehospital and Emergency Medical Services

Emergency Medical Services (EMS) and the entire prehospital system will play a major role during a CSC response. As first responders, EMS providers must adapt practices and standards of care to address the most difficult circumstances. During a CSC response, NMDOH senior leadership will issue guidance to EMS providers and authorities to ensure consistent care across the state and to assist EMS providers in dealing with an unexpected and potentially large number of patients.

#### Primary Triage

In a CSC response, primary triage will be required to optimize healthcare resources and do the greatest good for the greatest number of patients.

A variety of triage systems have been developed for use in emergencies and disasters. Triage protocols that should be considered during a CSC response in New Mexico include:

- START for adults
- JumpStart for pediatric patients
- Alternate Triage, Treatment and Transport Guidelines depending on the situation

All or some of these triage approaches may be used by first responders in a CSC response. NMDOH Senior Leadership Team in collaboration with the MAT will consider many factors when developing guidance for triage. Flexibility is needed to modify triage methods recommended by the New Mexico CSC Clinical Workgroup as additional evidence-based guidance is published regarding primary triage.

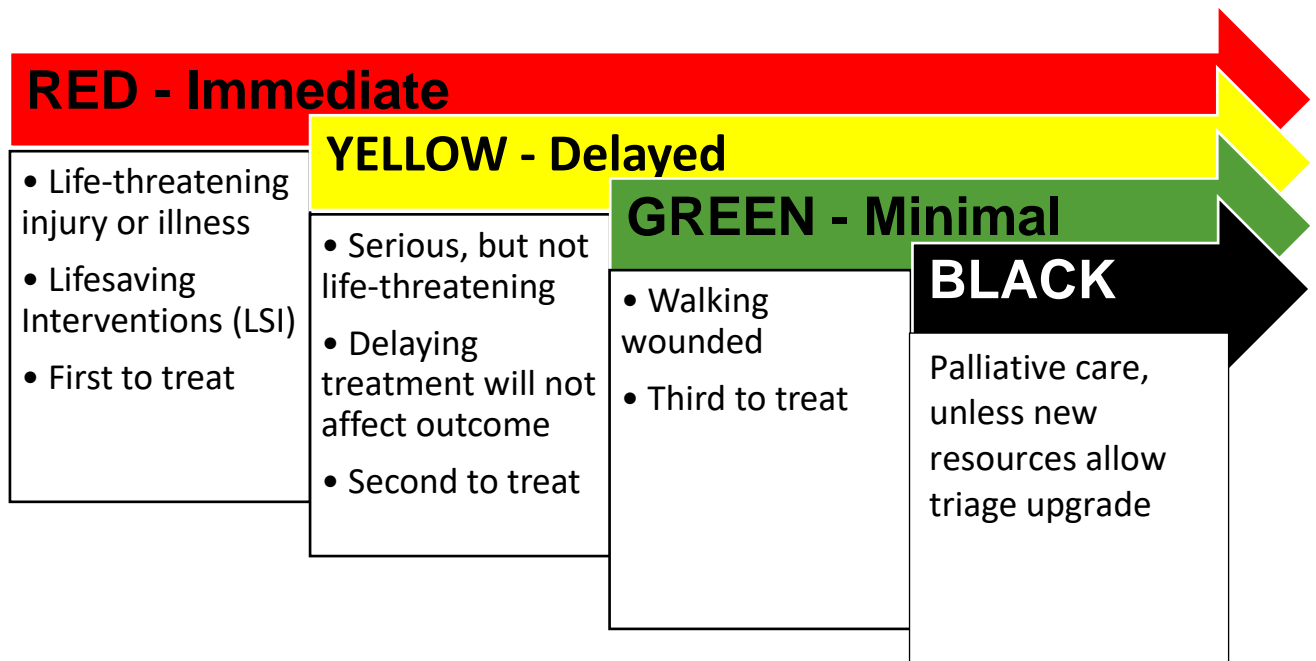
Additional evidence and ongoing literature review may become available for other triage methods such as:

#### **SALT**

- **S = Sort**
- **A = Assess**
- **L = Lifesaving interventions**
- **T = Treatment/Transport**



Table 3: Key Terms used in START and JumpStart Triage



**IDME (Immediate, Delayed, Minimal, Expectant) is a mnemonic to color-code and summarize the various acuity levels associated with many different triage methods.**

[http://www.emt.emszone.com/docs/Review\\_CH38.doc](http://www.emt.emszone.com/docs/Review_CH38.doc)

## Prehospital and EMS

1. Issue guidance to use START for adults or JumpStart for pediatrics during a statewide CSC response.
2. In the event of a pandemic, issue guidance to use the State's *Alternate Triage, Treatment and Transport Guidelines for Pandemic Influenza* for statewide CSC response.
3. Modify recommendations as additional evidence-based guidance is published regarding other primary triage methods.

## Hospital and Acute Care Facilities

This section applies to all hospitals with emergency departments as well as other types of acute care facilities, excluding long-term care facilities. Hospital and acute care facilities will play a critical role in all types of CSC responses. An overwhelming demand for medical care at hospitals may trigger the expansion of out-of-hospital care and the activation of alternate care sites and systems.

During a catastrophic response, hospitals may need to implement CSC guidance to address the surge of patients. NMDOH Senior Leadership in collaboration with the MAT will develop and disseminate guidance to help ensure consistent care across hospitals and other healthcare access points in New Mexico.

## Primary Triage

Primary Triage may occur at a hospital emergency department, clinic, or other healthcare access point. This situation applies when EMS transport is not involved (e.g., self-presenting patients at hospital emergency departments). The NM CSC Clinical Work Group has determined that hospitals and acute care facilities should use START for adults, JumpStart for pediatrics or emergency department triage levels 1–5 based on best practice and National Standard CSC recommendations. The NMDOH CSC Senior Leadership Team in collaboration and guidance from the MAT will have flexibility to modify these recommendations for hospital-based primary triage as additional evidence-based guidance is published.

## Secondary Triage

Secondary triage occurs after the first assessment and diagnostics, and after initial medical interventions. It is recommended that an acute care facility's medical expert, such as an emergency physician, intensivist, or trauma surgeon, is appointed to serve as the Secondary Triage Officer. This medical expert will help to determine the need and priority for the operating room (OR), computerized tomographic (CT) scanning, burn care, and other resources. During CSC activation, the Triage Officer's sole responsibility should be triage. The Triage Officer should not perform patient care or other functions.

***The NMDOH Senior Leadership Team will have the flexibility to modify these recommendations for hospital-based secondary triage as additional evidence-based guidance is provided by the MAT.***

## Tertiary Triage

Tertiary Triage occurs after primary and secondary triage. Tertiary triage is done in a hospital to prioritize patients for intensive care unit (ICU) admission. The New Mexico's CSC Clinical Workgroup recommends using the inclusion criteria and Sequential Organ Failure Assessment (SOFA) scores (detailed in CMJ 2006; 175 (11): 1377-1381,) <http://www.cmaj.ca/content/175/11/1377> as summarized in the following two tables: ICU admission priority is based on the Sequential Organ Failure Assessment (SOFA) Score that measures a patient's clinical data, including: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2703722/>

- Blood pressure
- Platelet count
- Glasgow Coma Scale (GCS)
- Creatinine, and bilirubin

**Table 4: CSC Criteria for ICU Admission**

<p><b>Needs a Ventilator</b></p> <ul style="list-style-type: none"> <li>• Refractory hypoxemia defined as an SpO2 less than 90% on a non-breather reservoir mask or an FIO2 greater than 0.85 or</li> <li>• Respiratory acidosis (pH less than 7.2) or</li> <li>• Clinically impending respiratory failure or</li> <li>• Inability to protect or maintain airway</li> </ul> <p style="text-align: center;">— ↓ OR ↑ —</p> <p><b>Hypotension</b></p> <ul style="list-style-type: none"> <li>• Systolic blood pressure (SBP) less than 90mmHg or relative hypotension with clinical evidence of shock, e.g., altered level of consciousness (LOC) or decreased urinary output, etc.</li> <li>• Refractory to volume resuscitation and requiring vasopressor or inotropic medic</li> </ul>
---

After the need for ICU admission has been established, the hospital Tertiary Triage Officer for CSC, usually an Intensivist, shall determine the priority for ICU beds based on the criteria listed in Table 4

**Table 4. indicates:**

- Patients with a SOFA score equal to or less than seven **7** have the highest priority for ICU admission. These highest priority patients are classified as “**red**”.
- Patients with a SOFA score of eight **8** through eleven **11** have intermediate priority for ICU admission and are classified as “**yellow**”.
- Patients with a SOFA score greater than **11** are classified as “**blue**” and have the lowest priority for ICU admission; they will receive palliative care as needed.
- Patients with no significant organ failure do not need ICU admission and are classified as “**green**”

**Table 5: SOFA Based Triage for ICU Admission Priority**

SOFA Triage Color Score	Criteria	ICU Admission Priority
<b>RED</b>	SOFA score < 7 or single organ failure	Highest priority for ICU admission
<b>YELLOW</b>	SOFA score 8-11	Intermediate priority for ICU admission
<b>BLUE</b>	SOFA score > 11	Lowest priority for ICU admission with palliative care prn
<b>GREEN</b>	No significant organ failure	No ICU admission necessary

## Hospital and Acute Care

Issue guidance to use START for adults, JumpStart for pediatrics, or emergency department triage levels 1–5 for primary triage for statewide CSC.

- Coordinate with facility Secondary Triage Officers.
- Issue guidance to use the inclusion criteria and SOFA score for tertiary triage per guidance

## Expanding Scopes of Practice

Scope of clinical practice is defined as the extent of a licensed healthcare professional's ability to provide services consistent with their competence, license, certification, and privileges. Most healthcare professionals' scopes of practice are delineated by rules and regulations describing range of responsibility, including extent and limits of procedures, actions, and processes, that a healthcare provider may undertake in keeping with the terms of their professional license, including requirements for training and continuing education.

Evidence of competence is required before a license to practice is issued by the professionals' state board. ***Any changes in scope of practice must be granted by the appropriate supervisory board and may require additional legislation.***

## Recommended CSC Expanded Scopes of Practice

1. EMTs and PAs may be supervised by a medical resident beyond their first year of residency (i.e., internship) in that resident's healthcare facility.
2. Residents beyond their first year of residency (i.e., internship) may function to the best of their ability in that Resident's healthcare facility.
3. A licensed physician beyond their first year of training (i.e., internship) may not be needed to practice in their assigned facility, but with advanced communication regarding specific needs, may go to another facility and practice under the supervision of a physician from the receiving facility.
4. Licensed New Mexico RNs who have met the requirements may perform procedures defined by the New Mexico Board of Nursing (NMBN) Advisory Opinions in facilities where they have privileges.
5. Any out-of-state, licensed healthcare professional in good standing may be approved to practice by that professional's New Mexico licensing board at that board's discretion during a CSC response.
6. Federal clinical professionals, under the supervision of a New Mexico licensed clinical professional with similar clinical responsibilities, may use their competencies and privileges obtained through their federal agencies to exercise their documented skills to assist with healthcare needs of the community.

<http://www.astho.org/Programs/Preparedness/Public-Health-Emergency-Law/Scope-of-Practice-Toolkit/Scope-of-Practice-Issues-in-Public-Health-Emergencies-Fact-Sheet/>

## Considerations for Supply Shortages

One of the key planning assumptions for CSC is shortages of space, staff, and supplies, as well as the short-term inability to receive shipments through regular channels or from emergency supply caches. Strategies and tactics to maximize resources will be necessary.

Consider the following when developing and issuing clinical guidance:

1. **SUBSTITUTE:** Use an essentially equivalent facility, professional, drug, or device for one that would usually be available.
2. **ADAPT:** Use a facility, professional, drug, or device that is not equivalent, but provides the best possible care.
3. **CONSERVE:** Use lower dosages or change practices (e.g., minimize use of oxygen by using air for nebulizers, when possible).
4. **REUSE:** Use single use items again, after appropriate disinfection or sterilization.
5. **OPTIMIZE ALLOCATION:** Allocate resources to patients whose need is greater or whose prognosis is more likely to result in a positive outcome with limited resources.

<http://www.kdheks.gov/cphp>

<https://www.ok.gov/health2/documents/Hospital%20Crisis%20Standards%20of%20Care.pdf>

**\* Adapted from The Guidelines for Use of Modified Health Care Protocols in Acute Care Hospitals During Public Health Emergencies, September 2013, Kansas Department of Health and Environment**

## Access and Functional Needs

During any incident involving emergency response and CSC Plan activation, NMDOH strategies will include and prioritize access and functional needs for the “whole community” during and after the event in accordance with the Office of Disability Integration and Coordination <https://www.fema.gov/office-disability-integration-and-coordination> guidance.

Based on the Department of Justice Guidance to State and Local Governments, the Americans with Disabilities Act, <https://www.ada.gov/> and potentially additional laws will be followed and applied regarding access and functional needs in all the following capabilities:

- Preparation
- Notification
- Evacuation and transportation
- Sheltering
- First aid and medical services
- Temporary lodging and housing
- Transition back into community
- Clean up
- Other emergency and disaster-related programs, services and activities

## Critical considerations supporting Access and Functional Needs

The terms “special needs” and “vulnerable” can do harm. When people with disabilities are thought of as “special”, they are often thought of as marginal individuals who have needs, not rights. The word “vulnerable” can have a similar effect. Vulnerable people can be perceived as needing to have things done for them as recipients, rather than engaging them as participants. In the setting of CSC, universal access refers to the ability or opportunity of all people to secure necessary emergency services including transportation, sheltering, education, evacuation, physical health and mental health services, and more, depending on the emergency.

- Self-Determination – People with access and functional needs are the most knowledgeable about their individual needs
- No “one-size-fits-all” – Not all individuals require the same assistance and not all have the same needs
- The population with access and functional needs must be able to access and benefit from emergency programs, services and activities equal to the general population, and that that include modifications to rules, policies, practices and procedures as indicated
- They must have the same inclusion rights to participate in and receive the benefits of emergency programs, services, and activities provided by governments, private businesses, and nonprofit organizations
- There must be integration into emergency programs, services and activities provided in an integrated setting
- They must have “physical access” to emergency programs, services, and activities provided at locations that all people can access
- The population with access and functional needs must be provided with effective communication comparable in content and detail to what the population without such needs receives. It must be accessible, understandable and timely.
- The population with access and functional needs will not be charged to cover costs of measures necessary to ensure equal access and nondiscriminatory treatment.

## Meeting Access and Functional Needs

Individuals with access and functional needs, including those with and without disabilities, can be accommodated with actions, services, equipment, accommodations and modifications including physical/architectural, programmatic, and communications modifications. Some individuals with functional needs have legal protections including, but not limited to, the right to freedom from discrimination based on race, color, national origin (Including limited English proficiency), sex, familial status, age, disability and economic status. Inclusive planning is expected to increase community-wide capacity to meet a wide range of disaster-related needs utilizing existing resources and reducing dependence on acute medical resources for maintaining health, safety and independence while preventing discrimination.

Individuals who have physical, sensory, behavioral and mental health, intellectual and cognitive disabilities, including: individuals who live in the community and individuals who are institutionalized; older adults with and without disabilities; individuals who are from diverse cultures, races, and nations of origin, individuals who don't read, have limited English proficiency or are non-English speaking; children with and without disabilities and their parents; individuals who are economically or transportation disadvantaged; women who are pregnant; individuals who have chronic medical conditions; those with pharmacological dependency, including those with a chemical dependency/addiction; other individuals who are often underrepresented or excluded and the social, advocacy and service organizations that serve individuals and communities.

### A whole community approach:

- Understanding and meeting the true needs of the entire affected community
- Engaging all aspects of the community
- Strengthening existing assets, institutions, and social processes

### Participation of the whole community requires:

- Equal access to national preparedness activities and programs without discrimination
- Meeting the access and functional needs of all individuals
- Consistent and active engagement and involvement in all aspects of planning

## Integration and Coordination

Integration and coordination of Access and Functional Needs in all phases of community-wide emergency management to strengthen the ability for protection against, respond to and recover from all hazards will be based on the <sup>1</sup>**C-MIST Framework**:

- **Communication**
- **Medical Care**
- **Independence**
- **Supervision**
- **Transportation**

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<sup>1</sup>C-MIST has been updated from June Isaacson Kailes' model for purposes of this training and other FEMA uses. The definition has moved away from utilization of a model of defining functional needs in medical terms toward a definition that more accurately addresses medical and nonmedical functional needs in the most integrated setting appropriate and to reduce or prevent decompensation and the development of acute medical conditions. Updates include describing potential barriers and strategies to achieve inclusion, integration, and self-determination; maintenance of health, safety, and independence; and prevention of discriminatory practices in emergency programs.<sup>1</sup>



The **C-MIST** Framework will be used to address a broad set of common access and functional needs in support of this CSC Plan.

The term “at-risk individuals” includes children, senior citizens, pregnant women, and others as deemed by the Secretary of HHS <sup>2</sup>The Pandemic and All-Hazards Preparedness Act (PAHPA), 42 § U.S.C. 300hh-16).

<https://www.gpo.gov/fdsys/pkg/PLAW-109publ417/pdf/PLAW-109publ417.pdf>

To ensure inclusive planning, HHS adopted the functional needs definition of at-risk individuals based on the **C-MIST Framework** and clarified the individuals who may need additional response assistance. The term “vulnerable populations” includes children, prisoners, pregnant women, mentally disabled persons, economically or educationally disadvantaged persons (CFR Title 45, Part 46).

<https://emilms.fema.gov/>

[https://www.fema.gov/pdf/about/odc/fnss\\_guidance.pdf](https://www.fema.gov/pdf/about/odc/fnss_guidance.pdf)

## Out-of-Hospital Care Providers

During a CSC activation and response, many healthcare access points across the state will need to adapt their practices to large numbers of patients seeking care. Ideally, the most acutely injured or ill patients will be routed to a hospital, and lower acuity patients will seek care in out-of-hospital settings. A CSC incident will likely be felt across the entire healthcare continuum as large numbers of people look for care wherever it can be found. Out-of-hospital care will be an important part of the CSC response and will naturally expand operations (e.g., extended hours of operation or repurposed infrastructure and equipment) to meet demand.

Out-of-hospital care refers to the following types of healthcare access points:

- Outpatient providers
- Clinics
- Surgical centers
- Long-term care facilities
- Group care
- Home care
- Family-based care systems

## Outpatient Providers

To ensure consistent care across the state, the NMDOH Senior Leadership Team, in collaboration with the MAT will coordinate CSC implementation and maintain situational awareness with all types of out-of-hospital providers. The size, duration, and scope (e.g., regional, statewide, and national) of the CSC response will determine the level of coordination between the NMDOH Senior Leadership and the provider community.

The development and implementation of guidelines for facilities and providers will be an interactive process between NMDOH Senior Leadership and the provider community.

The specific medical skills, infrastructure and equipment available to out-of-hospital providers will be considered during a CSC response:

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**Medical skills:** may be utilized in their usual practice environment, in alternate care systems/assignments (e.g., serving as members of the Medical Reserve Corps [MRC], answering patient hotlines), and perhaps in neighborhood/community settings.

**Infrastructure:** practice environments may be adjusted to help meet the demands of an overwhelming incident.

**For example, clinic functions may be:**

- **Expanded:** using expanded hours, modifying care practices, and adjusting schedules to accommodate increased acute care (and deferring elective appointments), clinics can “surge” to accommodate additional patients
- **Repurposed:** outpatient infrastructure may be repurposed during an incident as, for example, when a subspecialty clinic adjusts its hours or closes to enable the space to be used for acute care
- **Referred and routed:** outpatient providers will stay informed of existing healthcare access points and can refer or route patients to higher acuity care as appropriate during a CSC response (IOM, 2012).

<http://www.nationalacademies.org/hmd/Reports/2012/Crisis-Standards-of-Care-A-Systems-Framework-for-Catastrophic-Disaster-Response.aspx>

## Clinics

This category includes a wide variety of healthcare access points such as Urgent Care Centers, Federally Qualified Health Clinics (FQHC), multi-specialty clinics, and independently operated healthcare practitioners. For the purposes of this Plan, urgent care facilities, clinics located in retail stores, and pharmacies that provide basic medical screening are all considered to be clinics. Other types of non-traditional providers (e.g., dentists, veterinarians, and others) may also be considered as a part of this group.

## Surgical and Procedure Centers

Surgical and Procedure Centers may be repurposed to provide acute care, non-ambulatory hospital overflow care, or elective surgeries not possible at hospitals (e.g., during infectious disease incidents), depending on the demands of the incident, the specifics of the facility, and the needs of the community. The need for modified regulatory and licensure standards (e.g., changes in the scope of care) will need to be addressed in advance if federal, state, or local government entities (such as public health) authorize the delivery of triaged care in these facilities (IOM, 2012).

<http://www.nationalacademies.org/hmd/Reports/2012/Crisis-Standards-of-Care-A-Systems-Framework-for-Catastrophic-Disaster-Response.aspx>

## Long-Term Care Facilities

Several types of facilities are part of this category. Many long-term care facilities have limited surge capacity to accommodate hospital discharges, although they should not be overlooked as a resource. In general, the long-term care industry understands the disproportionate impact of certain incidents (e.g., infectious disease outbreak, pandemic influenza, evacuations) on their residents (AHRQ, 2007a).

<https://www.nap.edu/read/13351/chapter/6>

## Group Home and Congregate Environments

Organizations with on-site medical care (e.g., large business operations, group homes, schools, universities) can support dispensing or vaccination/ prophylaxis services in conjunction with NMDOH. Group homes and congregate settings may need to provide sheltering or isolation for residents/students/staff and may even need to conduct referral and routing of patients during a CSC response (IOM, 2012). <http://www.nationalacademies.org/hmd/Reports/2012/Crisis-Standards-of-Care-A-Systems-Framework-for-Catastrophic-Disaster-Response.aspx>

## Home Care/Durable Medical Equipment Vendors

During CSC, the NMDOH Senior Leadership Team will coordinate with home care/durable medical equipment vendors to prioritize their services based on the nature of an incident and adjust plans as the incident changes over time. These plans also should cover clients that are quarantined, isolated, or sheltering in place because of weather or other emergencies. Device-dependent persons should have a care plan in case of a system failure or power outage. Emergency departments may be inundated with patients' chronic care needs when home care cannot be continued. Home care and durable medical equipment vendors will play a critical role in providing basic medical equipment to individuals and facilities across the healthcare community (AHRQ, 2011)

<https://archive.ahrq.gov/research/findings/nhqrd/nhqrd11/qrd11.html>

## Family-Based Care

Many New Mexico residents receive care from family members, domestic partners, or cohabitants. Friends and continuum of care (contingency, conventional, and crisis) family members provide basic care to people with a wide variety of conditions including behavioral health issues, chronic diseases, end-of-life, developmental disabilities, and traumatic injuries. These non-clinical, ground level care providers can play a key role in preventing the medical system from being overloaded by helping limit unnecessary visits to healthcare providers and ensuring that at-risk people receive the most appropriate available care. To effectively reach these groups, public information messages should be disseminated statewide to inform the public of available healthcare resources for homebound persons and other at-risk groups. Families and friends should be prepared for expanded responsibilities during a catastrophic incident.

## Alternate Care Systems

Emergencies or disasters that impact the healthcare infrastructure, or cause many casualties, may require the establishment of alternate care sites and systems. For the purposes of this Plan, an alternate care site or system is not a routine part of the healthcare system but is activated or initiated during a disaster to meet the surging demand for healthcare services. Alternate Care Sites range in complexity and level of care and may be used during a CSC response to augment hospital-based and out-of-hospital care.

During ongoing CSC guideline development and implementation, NMDOH Senior Leadership with guidance from the MAT will assess the need for and impact of Alternate Care Site/System. The activation of Alternate Care Sites, such as deployment of a Federal Medical Station (FMS) or establishment of shelters providing basic medical care, will inevitably influence medical surge at nearby hospitals and other healthcare access points. Consequently, NMDOH Senior Leadership Team will coordinate and optimize Alternate care site/system strategies (e.g., placement, type, number) with healthcare system stakeholders.

The previous lists include many of the healthcare access points that are a routine part of healthcare in New Mexico and across the nation. During a public health disaster or CSC response, these providers and facilities will play an important role in reducing medical surge at hospitals. In addition to these traditional healthcare providers, alternate or contingency healthcare access points may also be identified and activated.

These include electronic care, ambulatory care, shelter medical care, non-ambulatory care overflow, emergency care replacement/overflow, and surgical/intensive care overflow (IOM, 2012 p. 5-6–5-9). When identifying strategies to maximize healthcare resources during a CSC response, NMDOH Senior Leadership Team in collaboration with the MAT will consider a variety of Alternate Care Sites including:

- Electronic Alternate Care Systems
- Ambulatory Care
- Shelter Medical Care – Mass Care
- Non-ambulatory Care (e.g., Federal Medical Station)
- Emergency Care Replacement Overflow
- Surgical/intensive Care or Inpatient Replacement/Overflow

The relationship between the degree of intervention at various Alternate Care Sites and the number of patients that can benefit from the intervention is defined by maximal interventions can only be offered to the smallest number of patients, while minimal interventions may be broadly delivered.

<https://www.nap.edu/read/13351/chapter/6>

## **Electronic Alternate Care Systems**

In the past, agencies across the United States have activated Call Centers and executed Social Media Campaigns with local partners to support public health emergency operations (e.g., Hurricane Katrina evacuation, 2009 H1N1 influenza pandemic, vaccine shortages). These practices and partnerships will be utilized and/or expanded to support CSC operations in New Mexico. Electronic Care Systems can be used to inform the public of protective actions and deliver basic health information to many people without surging inpatient or outpatient care settings. Online, telephone assessment and prescribing can be used to screen patients, routing them to higher acuity care as needed during many types of disasters.

NMDOH Senior Leadership, in collaboration with the MAT will develop guidance to ensure that electronic (e.g., online, telephone) referral policies and scripting are consistent across the state. Behavioral Health (SMEs) Subject Matter Experts will be consulted to ensure the development of appropriate guidance related to assessment and response.

Social media platforms may play a major role in Electronic Alternate Care Systems by providing information on protective actions and guidance on where and when to seek medical treatment. State and local resources such as Public Safety Answering Point (PSAPs), the NM Poison and Drug Information Center, and other state/local hotlines such as community information and referral should also be leveraged to provide telephone triage and screening. NMDOH Senior Leadership will coordinate closely with DOH PIO (Public Information Officer) to develop and disseminate consistent CSC messaging across the state via all available media platforms.

<https://www.nap.edu/read/13351/chapter/6>

## Ambulatory Care Facilities

Ambulatory Care Facilities (e.g., casualty collection points, “flu centers”) are intended to serve the minimally ill or injured who cannot be accommodated by the usual outpatient infrastructure. The need for such facilities, as well as their staffing and supply, varies greatly depending on the type and phase of the incident. Acute need for such sites may be seen during a pandemic or after a massive no-notice incident, such as an earthquake, large explosion, or another mass casualty incident (IOM, 2012). Healthcare facilities should coordinate with the Health Improvement Division staff prior to an event to develop procedures and MOU/MOAs to activate these facilities (units) on hospital grounds. Public sites may be initiated if the capacity of the healthcare system is overwhelmed or if selected populations or areas are disproportionately affected. These public sites also may be in nontraditional locations such as:

- Schools – College - University
- Dental Clinics
- Faith-affiliated Organizations
- Veterinary Clinics

Preplanned supplies for infectious disease and trauma incidents should be considered for ambulatory care facilities. It is important for facilities to work with Health Improvement Division to ensure that appropriate waivers are obtained; this work must be done in the pre-planning phase. Per the US Census Bureau, nearly 20% of Americans have a disability (access and/or functional need). Thus, general population shelters must be prepared to deal with basic to moderate healthcare needs. In New Mexico, the State Department of Health, Public Health Services, Emergency Management, and Access and Function Needs (AFN) organizations must be prepared to meet basic medical needs in general population shelters. During CSC, the DOH Senior Leadership in collaboration with the MAT will develop guidance for the delivery of healthcare at shelters based on available space, staff, and supplies.

<http://www.nationalacademies.org/hmd/Reports/2012/Crisis-Standards-of-Care-A-Systems-Framework-for-Catastrophic-Disaster-Response.aspx>

## Non-ambulatory Care/Hospital Overflow

Non-ambulatory Care/Hospital Overflow sites are typically set up in flat-space areas (convention or event centers, gymnasiums, armories), these sites provide overflow for patients that are non-ambulatory but have less intensive medical needs than hospitalized patients (IOM, 2012). Assets required to activate one of these sites would be coordinated and/or requested by the NMDOH Senior Leadership Team to include guidance for the activation and use of these non-ambulatory care sites that would serve as hospital overflow sites.

<http://www.nationalacademies.org/hmd/Reports/2012/Crisis-Standards-of-Care-A-Systems-Framework-for-Catastrophic-Disaster-Response.aspx>

## Federal Medical Stations

These 150-bed units are designed to provide basic non-ambulatory care to hospital overflow patients with minimal medical needs or to shelter patients with more advanced outpatient needs. They are designed to be moved into “structures of opportunity” in the community such as schools or convention centers. Although multiple federal medical stations are available, the supply is clearly inadequate for a multistate or national event (e.g., a pandemic, a major earthquake); the request and setup process require days.

Federal Medical Stations may be integrated with shelter-based or non-ambulatory care or be independent (ASPR, 2012). NMDOH Senior Leadership will collaborate with local, state, tribal, and federal partners to optimize the placement of federal medical stations  
[https://asprwgpublic.hhs.gov/ASPR/hhscapabilities/resourcedocs/Federal%20Medical%20Station%20\(FMS\).pdf](https://asprwgpublic.hhs.gov/ASPR/hhscapabilities/resourcedocs/Federal%20Medical%20Station%20(FMS).pdf)

## **Emergency Care Replacement/Overflow**

Usually provided in a specialty trailer or temporary specialty structure, emergency care replacement or overflow sites provide replacement capacity for damaged emergency departments (particularly in smaller communities). They also can provide temporary increased capacity for a single facility or area during a special event or major incident, particularly one involving healthcare or transportation infrastructure damage that limits access to emergency care. Healthcare facilities that activate an emergency care replacement/overflow site must do so, in coordination with the NMDOH Division of Health Improvement. The level of care provided often may be equal to that provided in a hospital environment (IOM, 2012). <http://www.nationalacademies.org/hmd/Reports/2012/Crisis-Standards-of-Care-A-Systems-Framework-for-Catastrophic-Disaster-Response.aspx>

## **Surgical/Intensive Care or Inpatient Replacement/Overflow**

Like the emergency care replacement/overflow sites, the surgical/intensive care or inpatient replacement/ overflow sites could provide services in areas where healthcare facilities are damaged or inadequate. Federal assets such as expeditionary medical facilities may fall into this alternate care site category.

<http://www.nationalacademies.org/hmd/Reports/2012/Crisis-Standards-of-Care-A-Systems-Framework-for-Catastrophic-Disaster-Response.aspx>



## Fatality Management

During CSC, structured planning and incident-specific guidance for mortuary services is critical to maintaining the dignity, and timely and orderly processing of the deceased, as well as social order. Incident-specific guidance for surge capacity mass mortuary sites should be developed in coordination with local medical examiners. In addition, guidelines should consider the National Disaster Medical System (NDMS) Disaster Mortuary Operational Response Team (DMORT) if available, as well as state-based resources to support a mass fatality response. NMDOH Senior Leadership Team guidance will be developed in accordance with the New Mexico Fatality Management Plan and Mass Casualty Plan appropriately

<https://www.phe.gov/preparedness/planning/hpp/reports/documents/capabilities.pdf>

[https://www.cdc.gov/phpr/readiness/00\\_docs/capability5.pdf](https://www.cdc.gov/phpr/readiness/00_docs/capability5.pdf)

<https://www.calhospitalprepare.org/mass-fatality-planning>



DRASH Shelter Systems

<http://www.reevesems.com/News/PressReleases.aspx?PressReleaseId=201>



## Pediatrics

Per the US Census Bureau, 23.4% of the population in New Mexico are under the age of 18.

<https://www.census.gov/quickfacts/fact/table/nm/PST045217>

Consequently, the availability of pediatric care will be a major concern during all types of disasters. As previously mentioned, JumpSTART will be used to triage pediatric patients during a CSC response. In addition to this pediatric-specific triage technique, many other aspects of the public health and medical disaster response must be tailored to meet the unique requirements and needs of children during disasters. These issues include but are not limited to:

- Communication
- Personal protective equipment (PPE)
- Decontamination
- Behavioral health
- Evacuation and transfer
- Family reunification
- Pediatric space
- Staff supplies

## Communication

Communication with pediatric patients, especially younger, non-verbal patients will present challenges during a CSC response. Hospitals, along with other healthcare access points, should be prepared to communicate basic information and provide companionship to children. The use of toys, pens and paper, coloring books, child-friendly signs, and other modalities may help children establish communication with caregivers and supervising adults during disasters.

## Personal Protective Equipment

PPE worn by healthcare providers may be frightening or strange to children. Thus, communication strategies must be in place to address fears and concerns. Additionally, pediatric sizes of masks and other types of PPE should be available for potentially infectious pediatric patients during transport or while in common areas.

## Pediatric Decontamination

The decontamination of pediatric patients will pose extra challenges for healthcare and emergency response personnel.

For example:

- Pediatric patients may be more susceptible to hypothermia and require tepid (98.6 °F) water during wet decontamination.
- Children may not be able to adequately wash themselves, follow verbal instructions, or use decontamination equipment.
- When possible, children should be sent through decontamination with an adult family member. Hospital decontamination teams should be prepared to accommodate children and their adult caregivers and provide instruction on how to effectively decontaminate all ages of patients.

## Pediatric Behavioral Health

Children will have unique behavioral health and psychological needs during disasters. Pediatric patients, both accompanied and unaccompanied, may be especially upset by the disaster and prone to fear and panic.

Consequently, hospitals and other healthcare access points will need to establish methods for emotional comfort, psychological assessments, and behavioral healthcare, ensuring coordination with appropriate behavioral health and social service providers.

## Pediatric Evacuation and Transfer

During a CSC response, pediatric patients need special considerations for the evacuation and transfer. If facilities are overwhelmed, then transfer to other in-state facilities will be necessary. If in-state capacity to evacuate/transfer pediatric patients is completely exhausted, transfer to facilities in other states will be implemented.

## Family Reunification

Family reunification is a major concern after any disaster requiring evacuation from the field or inpatient healthcare facilities. These issues are compounded when pediatric patients are evacuated or transferred to distant facilities out of the impacted area. Planning should involve the following considerations:

- Location and layout
- Staffing
- Supplies and equipment
- Planning and activation
- Pediatric safe area
- Security
- Just-in-time training
- Communications and information management
- Pediatric space, staff, and supplies

Under normal conditions, pediatric care requires specialized equipment, facilities, medications, and training. Per Activation Process and related MOU, a pediatric acute care facility will transfer patients when space, staff, and supplies are not available to meet the needs of patients. When patient transfer or evacuation is not possible, and resources are unavailable, medical facilities and personnel may be forced to adapt space, staff, and supplies to best accommodate pediatric patients.

The latest evidence-based research and guidance related to pediatric emergency care should be incorporated into a CSC response.

<https://archive.ahrq.gov/research/decontam.htm>

<https://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/Children-and-Disasters/Pages/Decontamination.aspx>

<https://www.phe.gov/Preparedness/planning/abc/Documents/2011-children-disasters.pdf>

## Palliative Care and Comfort Care

The following definition of palliative and comfort care, followed by the bulleted items are adapted from the World Health Organization <http://www.who.int/cancer/palliative/en/> The intent of palliative and comfort care is to improve the quality of life for patients and their families who face problems associated with life-threatening illnesses and injury, by preventing and relieving suffering, by means of early identification and treatment of pain and other, physical, psychosocial, and spiritual problems.

### Palliative and Comfort Care:

- Provide relief from pain and other distressing symptoms
- Affirm life and regard dying as a normal process it is not intended to neither hasten or postpone death
- Integrate the psychological and spiritual aspects of patient care
- Offer a support system to help patients live as actively as possible until death
- Offer a support system to help the family cope during the patient's illness and the family's bereavement
- When possible, uses a team approach to address the needs of patients and their families, including bereavement counselling, if indicated
- Enhance the quality of life and may positively influence the course of the illness or injury

Palliative and comfort care for children represent a special, albeit closely related field to adult comfort care. In addition to the above considerations, the following apply to pediatric patients:

- Palliative and comfort care for children are the active total care of the child's body, mind and spirit, and involves giving support to the family.
- Palliative and comfort care begin when illness is diagnosed and continues regardless of whether a child receives treatment directed at the disease.
- Healthcare professionals should evaluate and alleviate a child's physical, psychological, and social distress.
- When possible, effective comfort care requires a broad multidisciplinary approach that includes the family and makes use of available community resources; it can be implemented, even when resources are limited.

Palliative and comfort care can be provided in acute care facilities, out-of-hospital care, alternate care sites or in the children's homes.

- **Palliative care patients:**  
*Individuals who may benefit from available curative therapies*
- **Comfort care patients:**  
*Individuals for whom curative therapies are futile, given available resources*

During CSC, decisions must be made to balance needs for lifesaving care for those in triage categories who will likely benefit from treatment, while providing comfort care to those for whom lifesaving care is likely futile.

At a minimum, comfort care services for disaster victims will include relief of severe symptoms and providing comfort as people face end-of-life decisions.

The delivery of palliative and comfort care will be adapted per the type and severity of the disaster. NMDOH Senior Leadership will develop guidance for healthcare facilities and personnel, community responders, and other caregivers. It is the intent of this Plan to guide the delivery of consistent, compassionate, and equitable palliative and comfort care across the state. This applies to casualties of the CSC disaster, as well as patients facing end-of-life decisions from other illnesses and/or injuries.

Disaster triage is a dynamic process; therefore, patients initially triaged with START or JumpStart are at a higher priority than expectant may be re-triaged as expectant, if their condition deteriorates or resources are depleted. Patients with a SOFA score greater than 11 are the lowest priority for ICU admission and should receive available comfort care, as needed. NMDOH Senior Leadership will assist comfort care personnel, either medical or non-medical, by developing and issuing guidance specific to the scope and type of response.

## **Hospitals and Acute Care Facilities**

One key strategy during a CSC is to optimize resource use at hospitals and acute care facilities. One part of this is transferring palliative and comfort care patients to other care facilities. There are many types of healthcare facilities that may be able to assist with a surge of comfort care patients (e.g., out-of-hospital settings, alternate care sites). Hospice service providers may be engaged to deploy comfort kits for home-based comfort care.

During a CSC response, NMDOH Senior Leadership Team will coordinate with Triage Officers and Emergency Management Staff at healthcare facilities to facilitate transfer of existing palliative and new comfort care patients from acute care to other healthcare facilities or home healthcare settings. This will require coordination with the NMDOH Senior Leadership Team in collaboration with the MAT to develop guidance for healthcare professionals and facilities on delivering and continuing palliative and comfort care in a consistent and equitable manner across the state. This will include assessing the number of people needing comfort care versus the number of disaster casualties needing curative therapies or treatments.

Consideration will also be given to persons receiving comfort care or lifesaving treatments prior to the disaster. NMDOH Senior Leadership will need to assess available inventories, caches, and stockpiles of comfort care medications, supplies and equipment to develop recommendations for allocating scarce resources to palliative and comfort care patients.

## **Out-of-Hospital Facilities**

Depending on the type and severity of the response, NMDOH Senior Leadership may also develop guidelines for comfort care in non-hospital settings that do not normally provide care to medical surge patients. Long-term care facilities, which are familiar with providing palliative and comfort care, may be able to expand operations and take in disaster victims or evacuees from other facilities requiring end-of-life care.

To facilitate this, NMDOH Senior Leadership will coordinate with healthcare coalition partners to assess available beds and the ability to expand operations at long-term care and other facilities. This assessment should include both existing, licensed in-patient beds, as well as non-licensed emergency beds at alternate care sites.

## **Alternate Care Sites and Systems**

Alternate care sites (e.g., casualty collection points, shelter-based care, and federal medical stations) may be activated and used to provide palliative and comfort care. NMDOH Senior Leadership will consider these resources when developing statewide strategies and guidance for the delivery of comfort care. This will require coordination between healthcare coalitions, state, and federal partners.

## Just-in-Time Training

Based on the severity of the response, NMDOH Senior Leadership may need to consider just-in-time training recommendations for palliative and comfort care. These guidelines will address shortages of key resources (e.g., space, staff, and supplies) and will follow the strategies to maximize medical resources. Under the most extreme conditions, these training guidelines may address the use of non-medical personnel in the delivery of comfort care, including helping a patient take their own medications.

<https://www.phe.gov/coi/Documents/Palliative%20Care%20Considerations%20in%20Disaster%20Situations.pdf>

<https://www.nap.edu/catalog/13351/crisis-standards-of-care-a-systems-framework-for-catastrophic-disaster>

<http://palliativecare.org.au/download/10909/>

## Psychosocial Support

Medical intervention is only one component of palliative and comfort care. During a CSC response with limited clinical resources, psychosocial support may be the only available source of comfort. As with other types of clinicians, behavioral health staff and others qualified to provide psychosocial support in a disaster (e.g., social workers, religious/spiritual advisors, and other responders trained in psychological first aid) will be in short supply. NMDOH Senior Leadership will need to address this aspect of comfort care when developing guidance for healthcare professionals and other CSC responders in collaboration with MAT.

## Behavioral Health

During a CSC response, NMDOH Senior Leadership will consider three main issues related to behavioral health:

- Behavioral Health and psychosocial impact of the disaster on the public
- The behavioral health and psychosocial impact on first responders and medical professionals
- The impact of the disaster on the state's seriously mentally ill population, including continuation of care.

The NMDOH Senior Leadership and MAT (Medical Advisory Team) in collaboration with Human Services Division (HSD) will coordinate behavioral health services during a disaster to develop guidelines for the delivery of behavioral health services across the state during emergencies and disasters.

## General Population

In the aftermath of a disaster, many people may require behavioral health services to cope with grief and posttraumatic stress. Psychological first aid and social support systems will play an important role in addressing these issues. Incident-specific risk communication strategies should be developed and disseminated to help people manage the stress of the incident and direct listeners/viewers to additional resources as necessary. Community Resilience Programs that encourage neighbor-to-neighbor and family-to-family outreach are important. NMDOH Senior Leadership will coordinate with behavioral health experts to develop guidelines for behavioral health providers and risk communication messaging for the public

## Responders and Medical Providers

Responders and Healthcare Providers may be especially prone to post traumatic stress and other conditions during and after a CSC response. Peer-to-peer support, counseling, and other behavioral health support services (e.g., critical incident stress management (CISM)) may be useful for responders and providers.

CISM interventions may include a three-step approach:

- Defusing
- Debriefing
- Follow-up

## Mentally Ill Population and Continuation of Care

People with Serious Mental Illness (SMI) may be disaster victims (e.g., be injured, infected, or experience emotional crises related to the disaster). There are thousands of New Mexicans suffering from SMI that require ongoing behavioral health services, which may be disrupted during a disaster. As behavioral health providers, spiritual advisors, and social workers address the needs of disaster victims and palliative care patients, there will be an impact on the overall availability of resources for behavioral healthcare within the state.

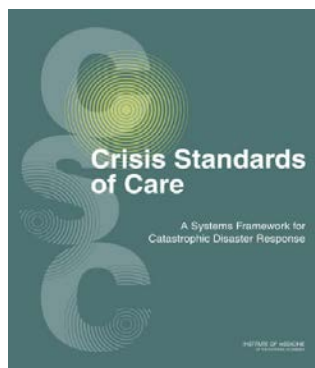
NMDOH Senior Leadership Team will consider both the ongoing treatment needs of the SMI population, as well as additional emotional and behavioral issues this group may experience because of the disaster. Behavioral health guidelines must address the continuation of substance dependency treatment, including the administration of medications.

[https://www.jhsph.edu/research/centers-and-institutes/center-for-law-and-the-publics-health/research/CDC\\_PERRC\\_Tool7.pdf](https://www.jhsph.edu/research/centers-and-institutes/center-for-law-and-the-publics-health/research/CDC_PERRC_Tool7.pdf)

<https://www.phe.gov/coi/Pages/iomcsc.aspx>

<http://www.acphd.org/media/330265/crisis%20standards%20of%20care%20toolkit.pdf>

<https://www.nap.edu/catalog/13351/crisis-standards-of-care-a-systems-framework-for-catastrophic-disaster>



## Organization and Assignment of Responsibilities for CSC Response

During a declared disaster or public health emergency, NMDOH Senior Leadership, in consultation with the Governor's Office, may activate the MAT to develop, recommend and disseminate Crisis Standards of Care across the state appropriately. The CSC MAT will also serve as a multi-disciplinary, interagency group for NMDOH Senior Leadership in keeping with ICS guidelines.

*\* At a minimum, the following positions should be considered for any response requiring CSC activation. Detailed descriptions of the qualifications, training, and responsibilities for each of these positions are included under the Plan Attachments*

- **Department of Health CSC Leadership Team**

The NMDOH Senior Leadership Team will require a wide range of medical professionals, public health experts, and official decision makers. The following list of positions provides a framework for defining the CSC Leadership Group. In keeping with ICS principles of flexibility and scalability, the makeup of the group will depend on the nature, scope, and severity of the disaster.

- **NM DOH Senior Leadership CSC Chair**

The Chair will manage the details of CSC guidance development and implementation. He/she will ensure timely development of CSC guidance and will coordinate CSC messaging with the Joint Information Center or System (JIC or JIS). This position will be the main point of contact for CSC planning, development and activating. This position will be filled by a senior staff member. He or she will have extensive knowledge of healthcare system preparedness and NMDOH operations.

- **MAT (Medical Advisory Team) Members**

Team members will be added to the MAT based on the specifics of the response. These members may be Program Managers or Medical Directors from Bureaus and Divisions within NMDOH and other agencies/organizations, such as emergency preparedness, emergency medical services and trauma systems, epidemiology, disease prevention and control, the NM State Public Health Laboratory, licensing agencies and organizations, behavioral health, immunization programs, or other areas, as needed. These staff members may have a dual role in the DOH DOC (Department of Health Disaster Operations Center), but may be called upon to assist with CSC guidance, recommendations and implementation

- **CSC Liaison**

The CSC Liaison will work under the direction of the Senior Leadership CSC Chair and will be responsible for coordinating CSC activities with DOC operations. He or she will communicate and coordinate with the DOC Director to relay decisions of the CSC Group and obtain logistical support for CSC operations.

- **Partner Agency CSC Member**

CSC guidance development will require input and representation from state agencies, counties, and tribal partners. The exact number of committee members will depend upon the scope and geographic reach of the catastrophe or emergency, but may include representation from state agencies, such as Emergency Management Attorney General's Office, the Governor's Office, Department of Education, NMDOH, and the state's Healthcare Coalitions.



Partner agency CSC group members will contribute to developing CSC, including guidance and priorities for allocating scarce medical resources. These committee members will also liaison between their respective agencies and the CSC MAT.

- **Healthcare CSC Member**

Input from healthcare representatives is vital to implementing CSC. The exact number of healthcare CSC members will depend upon the scope of the response. These individuals will contribute to developing statewide CSC guidance, including priorities for allocating scarce medical resources. They will also liaison between their respective healthcare entities and the CSC MAT. If the number of healthcare representatives is too large (e.g., greater than 20), it would be advisable to activate a regional group (e.g., state designated healthcare coalition) to coordinate CSC regionally and locally.

- **Subject Matter Expert CSC Group Member**

CSC guidance and development will require input from a variety of Subject Matter Experts (SMEs). The number and type of experts will depend upon the type and severity of the response. SMEs will provide technical information, data analysis, and advice related to the response. They will contribute to developing and implementing statewide CSC, including guidance and priorities for allocating scarce medical resources.

- **Clinical Care Committee Staff at Healthcare Facilities**

During a statewide CSC response, healthcare facilities will need to assign specific tasks to both clinical and incident command staff. The following staff descriptions can serve as a guide for healthcare facilities to use when developing or updating medical surge or CSC plans. These can be modified as needed to fit the Incident Command System in place at individual healthcare facilities or healthcare systems. Small healthcare facilities may only have one person available to implement CSC, whereas a large hospital may have a team of staff available. Planners should adjust these positions, as needed, but remember to separate the task of CSC triage from patient care, whenever possible.

- **Clinical Care Director**

In larger healthcare facilities, the Clinical Care Director will report to the facility Incident Commander or other designated lead and will coordinate CSC priorities and guidance within the facility's incident command. The Clinical Care Director will liaison between the CSC Leadership Group and the healthcare facility to provide situational awareness and implement CSC at the facility level.

- **CSC Triage Officer**

The CSC Triage Officer reports to the Clinical Care Director. He or she will triage patients per CSC priorities and guidance recommended by the CSC MAT. Healthcare facilities should consider developing separate job action sheets for Primary, Secondary, and Tertiary Triage Officers. RNs usually perform primary triage, whereas physicians typically perform secondary and tertiary triage. Most importantly, these Triage Officers should not be providing patient care to preserve objectivity.

## **Direction, Control & Coordination for CSC Senior Leadership**

The direction, control, and coordination of the CSC Senior Leadership Team will require an interagency, system-wide approach including four “levels” of response:

- State
- Regional
- Local
- Facility level

The relationship between the NMDOH DOC, the Healthcare Facilities Emergency Operations Center, and the CSC MAT will flow from the state down to the local and facility levels regarding guidance, recommendations and operational control and coordination. All CSC response entities must function together in a “systems approach” (IOM, 2012) to ensure delivering consistent, quality healthcare under the most extreme conditions. CSC will require a massive public information campaign. Partners from across the public health, medical, and emergency management communities must coordinate key messages, address public inquiry, and develop hazard-specific protective actions.

During CSC, all operating EOCs will participate in public information operations.

The NMDOH Senior Leadership Team will collaborate with the MAT and PIO to support and guide all risk communications components to include:

- Information gathering and analysis
- Information planning and production
- Information dissemination
- Agency spokesperson identification and preparation

DOH CSC Leadership Team in collaboration with the MAT will obtain real-time information from Incident Command Centers across the state and provide clear and consistent messaging regarding CSC operations. CSC members, representing their respective agencies or facilities, will be major sources of information.

## **Information Collection, Analysis and Dissemination**

### **Information Planning and Production**

The NMDOH Senior Leadership Team in collaboration with the MAT will develop media releases, talking points, and online content, regarding CSC. Close coordination with JIC staff will be required to ensure messaging is developed clearly and consistently across all jurisdictions. Special emphasis will be placed on developing messaging that reduces medical surge at affected facilities.

CSC staff should coordinate with risk communication professionals to create messaging that explains policies in a clear, easy-to-read and understand format to include other pre-identified and translated languages.

### **Information Dissemination**

The CSC Liaison will coordinate with the JIC to disseminate CSC guidance to healthcare providers, public health departments, emergency management agencies, and other stakeholders.

## Legal Considerations

During CSC, the demand for healthcare will force a shift from individual care to care for the “whole” community. This requires implementation of the values:

- Transparency
- Consistency
- Fairness
- Accountability
- Resiliency

An ethical framework is essential for development and implementation of tactics and strategies that cannot be added as an afterthought. Ethically and clinically sound planning will promote fair and equitable resource allocation to the whole community. The context of a disaster may make certain resources unavailable for some or even all patients, and—at the same time—requires attention to professional and legal standards. Healthcare professionals are obligated to provide the best care they reasonably can to each patient in their care at “all times” across the continuum of care. When resource scarcity reaches catastrophic levels, clinicians are ethically justified—and are ethically obligated—to use the available resources to sustain life and well-being to the greatest extent possible.

Emergency declarations trigger an array of non-traditional powers that are designed to facilitate response efforts through public and private sector that are critical responding to complex incidents across the continuum of care.

### Emergency Laws may:

- Provide government with sufficient flexibility to respond
- Mobilize central commands and infrastructures
- Encourage response efforts by limiting liability
- Authorize interstate recognition of healthcare licenses and certifications
- Allocate healthcare personnel and resources
- Help to change medical standards of care and scope of practice

The **IOM CSC Framework (2012)** identifies the following legal issues for healthcare practitioners and entities responsible for emergency preparedness:

- Personnel
- Access to treatment
- Coordination of health services
- Patient’s interest
- Resource allocation
- Liability
- Reimbursement
- Inter-jurisdictional cooperation

<https://www.nap.edu/catalog/13351/crisis-standards-of-care-a-systems-framework-for-catastrophic-disaster>

[http://www.aslme.org/media/downloadable/files/links/j/l/jlme-41\\_1-hodge-supp.pdf](http://www.aslme.org/media/downloadable/files/links/j/l/jlme-41_1-hodge-supp.pdf)

## Code of Ethics

### Overview

Ethical issues are pervasive in public health emergency responses. Examples include decisions related to the allocation and use of scarce resources, the appropriate application of limitations on personal liberty to protect the public, and the provision of public health and health care services to individuals and populations.

Lack of consensus for public health ethical norms applicable in emergencies has led to widely divergent approaches nationally and regionally. The Crisis Standards of Care Legal/Ethical Work Group will continue to work toward consensus-building efforts by bringing together public and private stakeholders to engage and collaborate in development of guidelines to assist in ethical decision-making in emergencies of catastrophic nature in New Mexico

### Goals

1. Create a mechanism to respond to the ethical and moral values of the community related to a paradigm shift from personal care to community care.
2. Address the legal barriers for the provision of optimal and ethical medical care and public health for emergency/crisis preparedness and response.
3. Develop generally-applied principles of public health emergency ethics via consensus among public and private stakeholders in New Mexico
4. Produce a consistent and reasonable public health emergency code of ethical behavior to help guide critical decisions among public and private sectors during public health emergencies.

### Application

Crisis Standards of Care ethical guidance will be applied to healthcare, public health, and emergency response and preparedness officials and practitioners in public and private sectors seeking to implement a crisis standard of care as defined by the National Academies of Science (IOM) Institute of Medicine. Crisis Standards of Care is not intended to apply to responses for localized emergency events of limited duration, state-wide emergencies that do not implicate the public's health, or events that do not require critical decisions on the use of scarce resources to protect or promote the public's health. Crisis Standards of Care is intended to supplement, not supplant, relevant portions of existing codes of ethics and professionalism for health care practitioners, hospitals, hospice care, public health practitioners, emergency responders, or other relevant persons or entities.

### Ethical Framework

Thompson, et al. described the Ethical Framework as consisting of two parts:

- Ethical process
- Ethical values

**Ethical processes** are designed to support and improve accountability, ideally with a method to obtain feedback and incorporate lessons learned.

**Ethical values** are designed to provide guidance, with acknowledgement that more than one value may be appropriate to a discussion.

While ethical processes and ethical values were not defined in explicit terms, based on *Thompson et al.'s description*, the procedural elements seem to refer to characteristics or qualities of the method or way a decision (based on ethical principles) is made. Ethical values represent aspects of an action or behavior executed based on ethical principles.

**Figure 8: The interplay between ethical processes and ethical values**

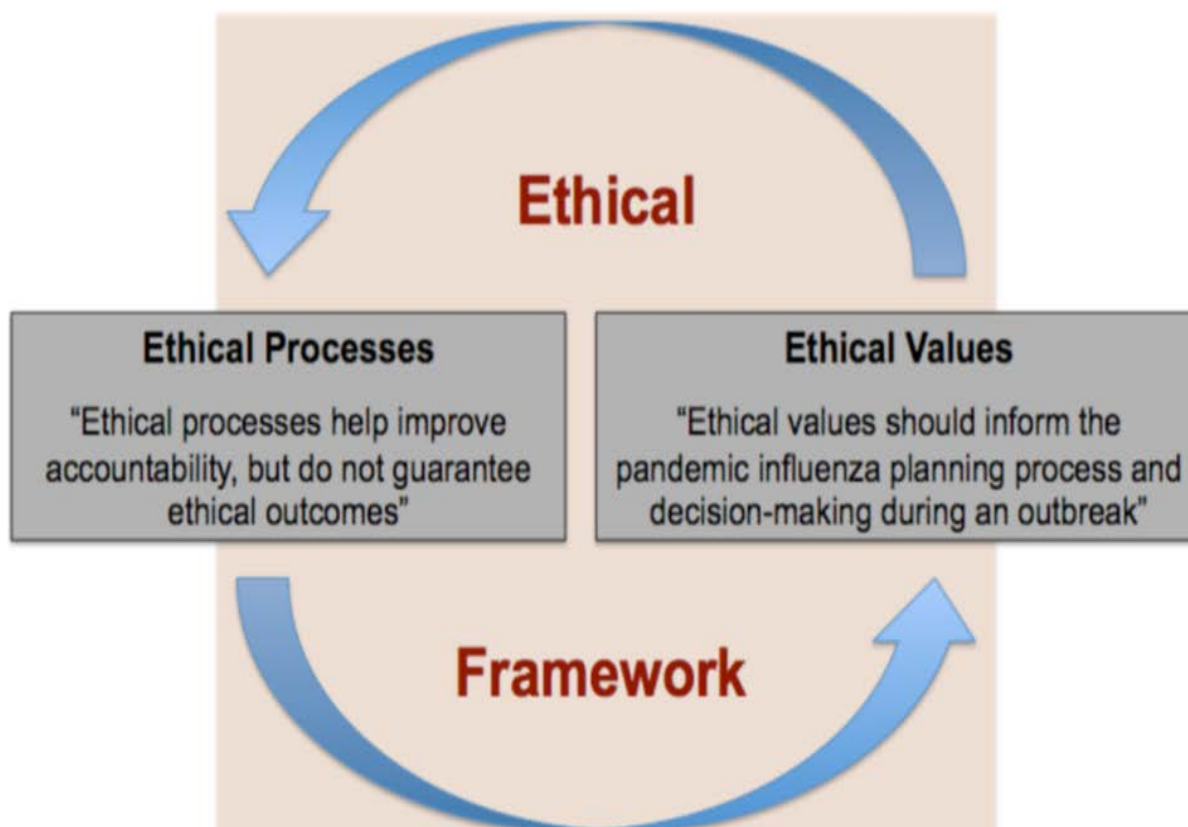


Figure created by the Litaker Group based on Thompson AK, Faith K Gibson, JL, and Upshur REG. Pandemic influenza preparedness: an ethical framework guide decision-making. *BMC Medical Ethics* 2006,7:12.

Medical Ethics Framework to Support Decision Making During Pandemic Influenza: Ethical Decision-Making Texas Department of State Health Services \* August 31,2010

<https://ajph.aphapublications.org/doi/abs/10.2105/AJPH.2017.303882?journalCode=ajph>



**Crisis Standards of Care  
Deactivation**



## Statewide CSC Deactivation

NMDOH Senior Leadership Team, in consultation with the Governor's Office and the MAT, will deactivate CSC when healthcare facilities are no longer operating at a crisis level. This deactivation will occur when all impacted healthcare facilities can meet patient demand using contingency-level surge standards, or when patient transfer or evacuation becomes a feasible tactic to alleviate crisis-level surge at affected healthcare facilities. In the case of a severe resource shortage prompting CSC, deactivation may occur when supply levels become sufficient to meet healthcare system demands. The following procedures will be employed to ensure a coordinated deactivation of CSC standards across the state:

- Throughout the response, EOCs, NMDOH Senior Leadership, and healthcare facility staff will analyze situation reports (SitReps), bed polls, and updates from healthcare system partners to determine the continued need for crisis-level care across the state.
- When at least 50% of impacted facilities (facilities at crisis-level) have returned to contingency level care, the MAT will coordinate with the JIC (Joint Information Center) to prepare health alert messages and public messaging to prepare for CSC deactivation.
- When it is anticipated that all healthcare facilities will return to contingency-level care within 48 hours, NMDOH Senior Leadership will inform healthcare partners statewide that it is anticipated that CSC will be rescinded within 48 hours. This timeframe will allow healthcare facilities to prepare for transitioning back to contingency surge, conventional surge, or normal operations, as appropriate.

When all impacted healthcare facilities can return to contingency-level care, or patient transfer/evacuation becomes possible to alleviate crisis-level conditions, NMDOH Senior Leadership, in consultation with the Governor's Office and the MAT, will deactivate CSC across the state.

It is important to note that the deactivation of CSC does not stop emergency operations at the state, local, or facility level. Emergency operations and emergency declarations may still be in place even though CSC has been deactivated.



ATTACHMENT 1.

# CRISIS STANDARDS OF CARE JOB ACTION SHEETS



## NMDOH Senior Leadership CSC Chair Crisis Standards of Care Job Action Sheet



### Recommended Qualifications and Training

- ✓ DOH Senior Leadership/ Director or Designee
- ✓ ICS 100, 200, 300, 400, 700, 800 training & certification
- ✓ Knowledge & training on DOC Standard Operating Guidelines (SOGs)
- ✓ NM State Emergency Operations Plan
- ✓ NM Department of Health Emergency Operations Plan
- ✓ New Mexico Crisis Standard of Care Plan

### Overall Responsibilities

- ✓ Activate the DOH Senior Leadership CSC Group
- ✓ Oversee the development and/or implementation of CSC guidelines by the Senior Leadership
- ✓ Coordinate with policy makers and elected officials to develop, implement, evaluate revise and deactivate the Plan.

### CSC Activation: First 12 Hours

- ✓ Consult with elected officials and recommend CSC activation as appropriate
- ✓ Authorize the DOC staff to convene the CSC Senior Leadership Group, i.e. identify and notify members, SMEs, jurisdictional partners, and private sector partners
- ✓ Meet with DOC Command Staff and CSC Senior Leadership members to establish incident specific policy goals and objectives for CSC

### CSC Operations: On-going

- ✓ Direct the development of policy, guidance, and priorities for CSC response
- ✓ Oversee coordination between EOC and DOH CSC Senior Leadership.

# NMDOH Senior Leadership CSC Liaison Crisis Standards of Care Job Action Sheet



## Recommended Qualifications and Training

- ✓ DOH Senior staff person (e.g. Assistant Director, Medical Director, Legislative Liaison, Bureau Chief (e.g. Public Health Emergency Preparedness, Emergency Medical Services, Epidemiology and Disease Control)
- ✓ ICS 100, 200, 300, 400, 700, 800 training & certification
- ✓ Knowledge & training on DOC Standard Operating Guidelines (SOGs)
- ✓ NM State Emergency Operations Plan
- ✓ NM Department of Health Emergency Operations Plan
- ✓ New Mexico Crisis Standard of Care Plan

## Overall Responsibilities

- ✓ Report to Senior Leadership CSC Chair
- ✓ Oversee CSC Senior Leadership operations
- ✓ Coordinate with DOC, and public information staff
- ✓ Ensure the development of timely guidance and priorities

## CSC Activation: First 12 Hours

- ✓ Coordinate with DOC Director to ensure CSC Senior Leadership members are identified and notified to serve on the CSC Senior Leadership Group
- ✓ Identify and supervise the CSC Senior Leadership Team activities with DOC operations
- ✓ Consult with CSC Chair, DOC Director, Public Information Officer, and other Leadership staff to establish goals and objectives for CSC Senior Leadership operations
- ✓ Conduct initial meeting(s) with CSC Senior Leadership Group members to develop guidance and priorities for treatment and allocation of scarce medical resources
- ✓ Verify with DOC staff (e.g., DOC Director) timely distribution of CSC guidance and priorities within the first 12-hour operational period

## CSC Operations: On-going

- ✓ Work with DOC Director to monitor and track the dissemination and implementation of CSC priorities and guidelines across the healthcare system
- ✓ Revise and re-distribute CSC priorities and guidelines as needed.

## NMDOH Medical Advisory Team (MAT) Crisis Standard of Care Job Action Sheet



### Recommended Qualifications and Training

- ✓ Senior staff person (e.g. Medical Directors, Bureau Chiefs, Managers/Supervisors from key Divisions, Departments and Programs such as BHEM, HPP, ERD, PHEP, EMS, HSD, Licensing, etc.
- ✓ ICS 100, 200, 300, 400, 700, 800 training & certification
- ✓ Knowledge & training on DOC Standard Operating Guidelines (SOGs)
- ✓ NM State Emergency Operations Plan
- ✓ NM Department of Health Emergency Operations
- ✓ New Mexico Crisis Standard of Care Plan

### Overall Responsibilities

- ✓ Collaborate with the Senior Leadership Chair, CSC Liaison and other critical partners overseeing DOH Senior Leadership operations
- ✓ Coordinate DOH Senior Leadership functions in assigned program areas
- ✓ Coordinate with DOC, and public information staff
- ✓ Contribute to the timely development of CSC guidance and priorities for treatment

### CSC Activation: First 12 Hours

- ✓ Work with DOC Director and staff as needed to coordinate guidance and priority development and dissemination
- ✓ Consult with DOC Director, Agency Director, Public Information Officer, and other Command Staff to establish goals and objectives for CSC Senior Leadership operations for assigned program areas
- ✓ Participate in initial meeting(s) with DOH Senior Leadership Group members to develop guidance and priorities for treatment and allocation of scarce medical resources

### CSC Operations: On-going

- ✓ Monitor and track the dissemination and implementation of CSC guidance and priorities related to assigned program area through collaboration with DOC staff and Senior Leadership members
- ✓ Assist with revising and re-distributing CSC guidance and priorities as needed.

# NMDOH CSC Liaison to DOC Crisis Standard of Care Job Action Sheet



## Qualifications and Training

- ✓ DOH staff person with knowledge of healthcare system, regulatory environment, public health, and medical surge
- ✓ ICS 100, 200, 300, 400, 700, 800 training & certification
- ✓ Knowledge & training on DOC Standard Operating Guidelines (SOGs)  
NM State Emergency Operations Plan, NM Department of Health Emergency Operations Plan and the New Mexico Crisis Standard of Care Plan

## Overall Responsibilities

- ✓ Report to the Policy Group Advisor
- ✓ Coordinate CSC Senior Leadership operations with DOC operations
- ✓ Work with DOC staff to obtain resources for DOH Senior Leadership operations

## CSC Activation: First 12 Hours

- ✓ Coordinate with DOC Manager and staff to ensure that logistical requirements are in place to Support virtual and/or on-site CSC Senior Leadership operations
- ✓ Develop reports (see DOC forms) for first operational period, reports shall include name, organization, and contact information for all CSC Leadership members
- ✓ Take meeting minutes for initial CSC Senior Leadership meetings and/or conference calls
- ✓ Work with DOC Manager and PIO staff to ensure that distribution lists are in place for the dissemination of CSC priorities and guidelines to response partners and the public within the first 6 hours of operation
- ✓ Under the direction of the Policy Advisor work with DOC staff (e.g., DOC Manager, Logistics Section Chief) to draft and distribute CSC guidance and priorities within the first 12-hour operational period

## CSC Operations: On-going

- ✓ Serve as the primary point of contact for CSC Senior Leadership members
- ✓ Serve as the primary point of contact between the CSC Senior Leadership and the DOC for logistical and operational support
- ✓ Ensure meeting minutes are produced for every in-person meeting, conference call, or web Conference and distributed appropriately
- ✓ Ensure status reports are produced for every operational period
- ✓ Under the direction of the Policy Advisor, compile and draft revised CSC guidance and priorities
- ✓ Work with DOC Manager and staff to ensure that CSC distribution lists are maintained and updated accordingly to reflect the dynamic environment.

## Partner Agency Committee Member Crisis Standard of Care Job Action Sheet



### Qualifications and Training

- ✓ Public health, emergency management, or another stakeholder from local, state, or federal agencies, or a representative from a state medical board or association.
- ✓ ICS 100, 200, 300, 400, 700, 800 training & certification
- ✓ Knowledge of government, healthcare system, emergency management, or public health Emergency preparedness
- ✓ Knowledge & training on DOC Standard Operating Guidelines (SOGs) NM State Emergency Operations Plan, NM Department of Health Emergency Operations Plan and the New Mexico Crisis Standard of Care Plan

### Overall Responsibilities

- ✓ Contribute to the development and implementation of statewide CSC guidance and priorities for the allocation of scarce medical resources
- ✓ Liaison between respective agency and the DOH CSC Senior Leadership

### CSC Activation: First 12 Hours

- ✓ Confirm receipt of notification message from DOC requesting participation in DOH Senior Leadership operations
- ✓ Participate in initial meeting or conference call
- ✓ Assist with information gathering and situational awareness from local/regional jurisdictions and/or healthcare facilities
- ✓ Contribute to the development of initial status report, meeting minutes and other documentation as required
- ✓ Under the direction of the Policy Advisor, collectively develop initial CSC guidance and Priorities with other CSC Senior Leadership members

### CSC Operations: On-going

- ✓ Serve as the primary point of contact between the CSC Senior Leadership and the local/regional agency
- ✓ Continue to gather information and provide situational awareness from local/regional jurisdiction and healthcare facilities
- ✓ Contribute to the development of on-going status reports, meeting minutes, and other documentation as needed
- ✓ Work collectively with CSC Senior Leadership staff to evaluate and update guidance and priorities as needed.

## Healthcare Committee Member Crisis Standard of Care Job Action Sheet



### Qualifications and Training

- ✓ Stakeholder from a Healthcare Coalition Leadership, healthcare network, EMS/pre-hospital, board, or association involved in the CSC response
- ✓ ICS 100, 200, 700, 800 recommended
- ✓ Knowledge of healthcare system, public health emergency preparedness, and medical surge
- ✓ Knowledge & training on DOC Standard Operating Guidelines (SOGs)  
NM State Emergency Operations Plan, NM Department of Health Emergency Operations Plan and the New Mexico Crisis Standard of Care Plan

### Overall Responsibilities

- ✓ Contribute to the development and implementation of statewide CSC guidance, including guidelines and priorities for the allocation of scarce medical resources
- ✓ Liaison between healthcare entity and CSC Senior Leadership during CSC operations

### CSC Activation: First 12 Hours

- ✓ Confirm receipt of notification message from DOC requesting participation in CSC Senior Leadership operations
- ✓ Participate in initial meeting or conference call
- ✓ Assist with information gathering and situational awareness from healthcare organizations
- ✓ Contribute to the development of initial status report, meeting minutes and other documentation as required
- ✓ Under the direction of the Policy Advisor, collectively develop CSC priorities and guidelines with other CSC Senior Leadership members

### CSC Operations: On-going

- ✓ Serve as the primary point of contact between the CSC Senior Leadership and the healthcare organization
- ✓ Continue to gather information and provide situational awareness from healthcare organization
- ✓ Contribute to the development of on-going status reports, meeting minutes, and other documentation as needed
- ✓ Work collectively with CSC Senior Leadership staff to evaluate and update guidance and priorities as needed.



# Clinical Care Director Crisis Standard of Care Job Action Sheet



## Qualifications and Training

- ✓ Physician
- ✓ Knowledge of healthcare system, public health emergency preparedness, and medical surge
- ✓ Hospital Incident Command System (HICS)
- ✓ Review Crisis Standard of Care Plan

## Overall Responsibilities

- ✓ Oversee the implementation of CSC priorities and guidelines at healthcare facility
- ✓ Coordinate between CSC Senior Leadership and healthcare facility
- ✓ Coordinate CSC guidance and priorities with facility emergency operations
- ✓ Provide situational awareness related to medical surge and CSC to DOH CSC Senior Leadership as appropriate

## CSC Activation: First 12 Hours

- ✓ Confirm receipt of CSC guidance and priorities from CSC Senior Leadership
- ✓ Identify and supervise Triage Officer(s)
- ✓ Brief Incident Command and clinical staff to inform them of CSC guidance and priorities
- ✓ Ensure that Triage Officers are in place so that clinicians providing patient care are solely focused on the survivorship of the patients under their care
- ✓ Develop report outlining CSC activities for initial operational period per facility policy

## CSC Operations: On-going

- ✓ Coordinate with Incident Command to provide situational awareness for local and state response agencies and the DOH CSC Senior Leadership
- ✓ Contribute to the development of facility status reports, meeting minutes and other documentation as required
- ✓ Ensure separation of duties between Triage Officer(s) and clinicians providing patient care
- ✓ Consult with Incident Command staff regarding the need for critical incident stress management (CISM), psychological first aid, or other behavioral health support for Triage Officers and healthcare practitioners/ professionals involved in CSC implementation
- ✓ Work with Incident Command Staff and Clinical Director to determine incident-specific thresholds for deescalating CSC into either contingency or conventional care.

# CSC Triage Officer Crisis Standard of Care Job Action Sheet



## Qualifications and Training

- ✓ Physician or qualified triage nurse
- ✓ Knowledge of healthcare system and medical surge
- ✓ Hospital Incident Command System (HICS)
- ✓ Critical Incident Stress Management (CISM) training as required
- ✓ Review Crisis Standard of Care Plan

## Overall Responsibilities

- ✓ Reports to the Clinical Care Director
- ✓ Triage patients per CSC guidance and priorities developed and implemented by the DOH CSC Senior Leadership
- ✓ Reports space, staff, and supply needs to the facility emergency operations center
- ✓ Provide information to the Clinical Care Director for inclusion in status reports

## CSC Activation – First 12 Hours

- ✓ Attend initial briefing with Clinical Care Director to discuss CSC implementation
- ✓ Perform primary (RN), secondary (ED Physician), and tertiary (intensivist or physician of comparable status) triage of patients as needed to support CSC operations
- ✓ Refrain from providing patient care to ensure objectivity

## CSC Operations – On-going

- ✓ Attend regular briefings with Clinical Care Director, and facility incident command staff
- ✓ Continue to perform triage of patients as directed to support CSC operations
- ✓ Continue to refrain from providing patient care to ensure objectivity
- ✓ Consult with Clinical Care Director regarding the need for critical incident stress management (CISM), psychological first aid, or other behavioral health support for healthcare provider involved in CSC implementation
- ✓ Work with Incident Command Staff and Clinical Director to determine incident-specific thresholds for deescalating CSC into either the contingency or conventional care.

## ATTACHMENT 2.

### Legal References

- Department of Health Act, Sections 9-7-1, et seq., NMSA 1978
- State Civil Emergency Preparedness Act, Sections 12-10-1, et seq., NMSA 1978
- Public Health Emergency Response Act, Sections 12-10A-1, et seq., 3NMSA 1978
- Public Health Emergency Response Act, Section 12-10A-6.C, NMSA 1978
- State Civil Emergency Preparedness Act, Sections 12-10-11 through 13, NMSA 1978.
- Public Health Act, Sections 24-1-1, et seq., NMSA 1978
- Emergency Medical Systems Fund Act, Sections 24-10A-2, et seq., NMSA 1978
- Emergency Medical Systems Act, Sections 24-10B-1, et seq., NMSA 1978
- Medical Investigations, Sections 24-11-1 to 24-11-10, NMSA 1978
- Disposition of Dead Bodies, Sections 24-12-1 to 24-12A-3, NMSA 1978
- Burial of Indigents, Sections 24-13 -1, et seq., NMSA 1978
- Annex 5, ESF 6 Public Health, Medical & Mortuary.
- Robert T. Stafford Disaster Relief and Emergency Assistance Act, as amended by Public Law 106-390, October 30, 2000

<https://www.amr.net/solutions/federal-disaster-response-team/references-and-resources/crisis-standards-of-care-2012-iom-w-core-function.pdf>

[http://www.ehcca.com/presentations/emsummit5/grimm\\_2.pdf](http://www.ehcca.com/presentations/emsummit5/grimm_2.pdf)

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[https://www.researchgate.net/publication/264989435\\_Legal\\_Preparedness\\_Care\\_of\\_the\\_Critically\\_Ill\\_and\\_Injured\\_During\\_Pandemics\\_and\\_Disasters\\_CHEST\\_Consensus\\_Statement](https://www.researchgate.net/publication/264989435_Legal_Preparedness_Care_of_the_Critically_Ill_and_Injured_During_Pandemics_and_Disasters_CHEST_Consensus_Statement)

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<https://asu.pure.elsevier.com/en/publications/practical-ethical-and-legal-challenges-underlying-crisis-standard>

<http://currents.plos.org/disasters/article/developing-a-health-system-approach-to-disaster-management-a-qualitative-analysis-of-the-core-literature-to-complement-the-who-toolkit-for-assessing-health-system-capacity-for-crisis-management/>

## ATTACHMENT 3.

### Core Guidelines

**1. Stewardship of Resources.** To the extent possible scarce resources must be managed during a public health emergency to prevent morbidity and mortality while maintaining respect and care for individuals and the community.

**1.1. Duty to plan.** Decision-makers must plan and develop affirmative, advance guidance for health care providers, health care practitioners, emergency responders, and others involved in the emergency response.

**1.2. Triage allocation plan.** Decision-makers must develop an advance triage allocation plan for scarce, essential resources that is consistent with the principles and rules of this Code

**1.3. Specificity.** To ensure that guidance on resource allocation is most effective, uniformly applied and comprehensible, guidance will be as specific as possible.

**1.4. Duty to recover and restore.** Decision-makers must develop plans to recover and restore resources mobilized during the emergency.

**2. Duty to Care.** To the extent possible, health care providers and practitioners have a duty to provide care during public health emergencies

**2.1. Duty NOT to abandon.** Health care providers and practitioners, to the extent possible, will triage patients to the most feasible level of care and will NOT abandon patients who have a reasonable expectation of care based on prior commitments and available resources.

**2.2. Duty to care despite risks.** Health care practitioners are ethically obligated to (a) provide care to the extent such care is effective and appropriate (Soundness) even if doing so will expose them to greater than normal risks to their own health, and (b) avail themselves of relevant and available protective measures. A health care practitioner's duty to care is balanced against reciprocal ethical obligations that society and institutions owe practitioners (Reciprocity), as well as against competing ethical obligations practitioners may have to their families or others to whom they owe a duty of care.

**2.3. Duty to provide comfort care.** To the extent possible, patients who are ineligible to receive limited allocations of scarce preventive, life-saving, or life-sustaining resources or services for any reason will be offered available forms of curative, palliative and/or preventative treatment or services.

**3. Soundness.** To the extent possible, responses in public health emergencies will be consistent with known or empirically-supported "best practices."

**3.1. Effectiveness.** Responses will be demonstrably effective and based on existing data or known efficacy.

**3.2. Priority.** Responses will prioritize protecting the public from preventable causes of morbidity and mortality.

**3.3. Non-Diversion.** Essential emergency resources will not be diverted to address non-emergency conditions.

**3.4. Information.** Decision-making will be based on solid, well-informed situational awareness, promote consistency, be coordinated with others involved in the response, and limit, ad hoc decisions

**.5. Appropriateness.** Decision-makers will be duly qualified (or consult with those who are qualified) to understand and assess public health and ethical consequences and alternative courses of action.

**3.6. Risk Assessment.** Responses will undergo risk assessment when possible to avoid creating additional undue risks to others or undermining response efforts to the greater harm of the larger community.

**3.7. Flexibility.** Public and private sector decision-making processes must be flexible and revisable to reflect current information based on the prevailing and emerging circumstances.

**4. Fairness.** In a public health emergency, to the extent possible, similarly-situated individuals and groups will be treated in similar ways. (A disability in and of itself is NOT criteria for decision-making

**4.1. Consistency.** To the extent possible, decision-making criteria and methodology will be applied consistently across settings, populations, institutions, and jurisdiction

**4.2. Justice.** Public health responses and allocation of scarce resources (such as vaccines, ventilators, or evacuation assistance) may not be based on factors unrelated to health status and emergency response needs.

Impermissible factors include, but are not limited to:

- **Race**
- **Gender**
- **Ethnicity**
- **Religion**
- **Social Status**
- **Location**
- **Education**
- **Income**
- **Ability to pay**
- **Disability unrelated to prognosis**
- **Immigration status**
- **Sexual orientation**

**4.3. Medical need and prognosis.** Allocations of scarce medical resources will prioritize individuals or groups with greater medical needs, based on:

- **Medical prognoses,**
- **Likelihood of positive medical response to available treatment or services,**
- **Relative risk of harm posed by withdrawing or withholding treatment, or**
- **Other indicators of survivability.**

**5. Reciprocity.** To the extent possible, those who face disproportionate burdens or greater risks for the benefit of the community in public health emergencies will receive additional support.

**5.1. Protections for individuals.** To encourage compliance with voluntary public health restrictions (such as quarantine, social distancing measures, or disease reporting), affected individuals' compliance will be recognized through measures that protect them from job loss and negative repercussions such as but limited to immigration status or job loss.

**5.2. Protections for essential personnel.** Health care practitioners, emergency first responders, and others who perform or support essential emergency functions will receive priority for protective measures in limited supply (e.g., vaccines or protective equipment) and will receive other protections or services (e.g., childcare services, workers' compensation coverage, or limited liability protections) as the ability to provide these services exists.

**5.3. Protections for essential providers.** Additional support and resources will be allotted to health care providers that take on disproportionate financial or logistical burdens as part of emergency response efforts.

**6. Proportionality.** To the extent possible, the least restrictive means (vaccination, shelter in place, isolation, quarantine) will be used during a public health emergency, reserving restrictive measures only for when they are essential to effective response.

**6.1. Balancing obligations.** Decision-makers will balance obligations to protect community health with respect for individual liberties and other interests. If more than one equally effective option exists, decision-makers must choose the option that poses the fewest risks to individual liberty, privacy, justice, or other legally- or ethically-grounded rights.

**6.2. Limited application and duration.** To the extent possible and consistent with public health purposes, restrictive measures (e.g., isolation, quarantine, curfews, or other social distancing efforts) will be voluntary and imposed only if it is determined that other public health measures are insufficient or unavailable. Restrictive measures must be limited in duration and not be continued after significant risks to individuals or the public's health have abated.

**6.3. Well-targeted.** Restrictive measures must be well-targeted to apply only to individuals or groups in the population who must be restricted to avoid significant risks to the public's health.

**6.4. Privacy.** To encourage compliance with recommended screening programs and other interventions, decision-makers will respect individual and group privacy and confidentiality expectations (per institutional and/or governmental policy) to the best of their ability. The rationale for sharing identifiable personal health or other data to protect the public's health will be clearly communicated.

**7. Transparency.** To the extent possible, policy decisions and their justifications prior to and during public health emergencies will be open to the public with opportunities for public consultation and input.

**7.1. Public engagement.** Plans for public health emergency responses, including specific methods for allocation of scarce resources and decisions regarding any limitations on personal liberties, will be made available to the public. Public input and comment will be solicited and considered to the extent possible consistent with public health purposes, given time and circumstance.

**7.2. Openness.** To the extent possible decisions that affect the public will be communicated consistently, openly, honestly, and in a through manner.

**7.3. Communication systems.** Decision-makers will use multiple, available, and effective communication systems to consult with various relevant stakeholders and the public.

**7.4. Documentation.** Decisions will be documented to the extent possible

**7.5. Full disclosure.** Emergency responders will be fully informed of the known risks prior to participating in the response and informed of developing risks as they become known to the extent possible.

**7.6. Accessibility.** Decision-makers will communicate vital information in a way that is accessible to those of different ages, disabilities, and linguistic abilities to the extent possible

**8. Accountability.** Decision-makers and individuals are responsible for their actions (or failures to act) in a public health emergency.

**8.1. Individual responsibility.** All individuals are responsible for the consequences of their decisions of compliance or non-compliance with emergency response orders or recommendations. Those who choose not to comply with public health emergency measures (e.g., evacuation, quarantine or vaccination) may lose access priority for future aid to the extent the need for such aid stems from their prior decisions

**8.2. Duty to evaluate.** To the extent possible, decision-makers must monitor the effects and evaluate the efficacy of decisions and responses implemented.

**8.3. Public accountability.** Decision-makers are accountable for failures to abide by applicable crisis standards of care or the principles and guidelines articulated by this Code.

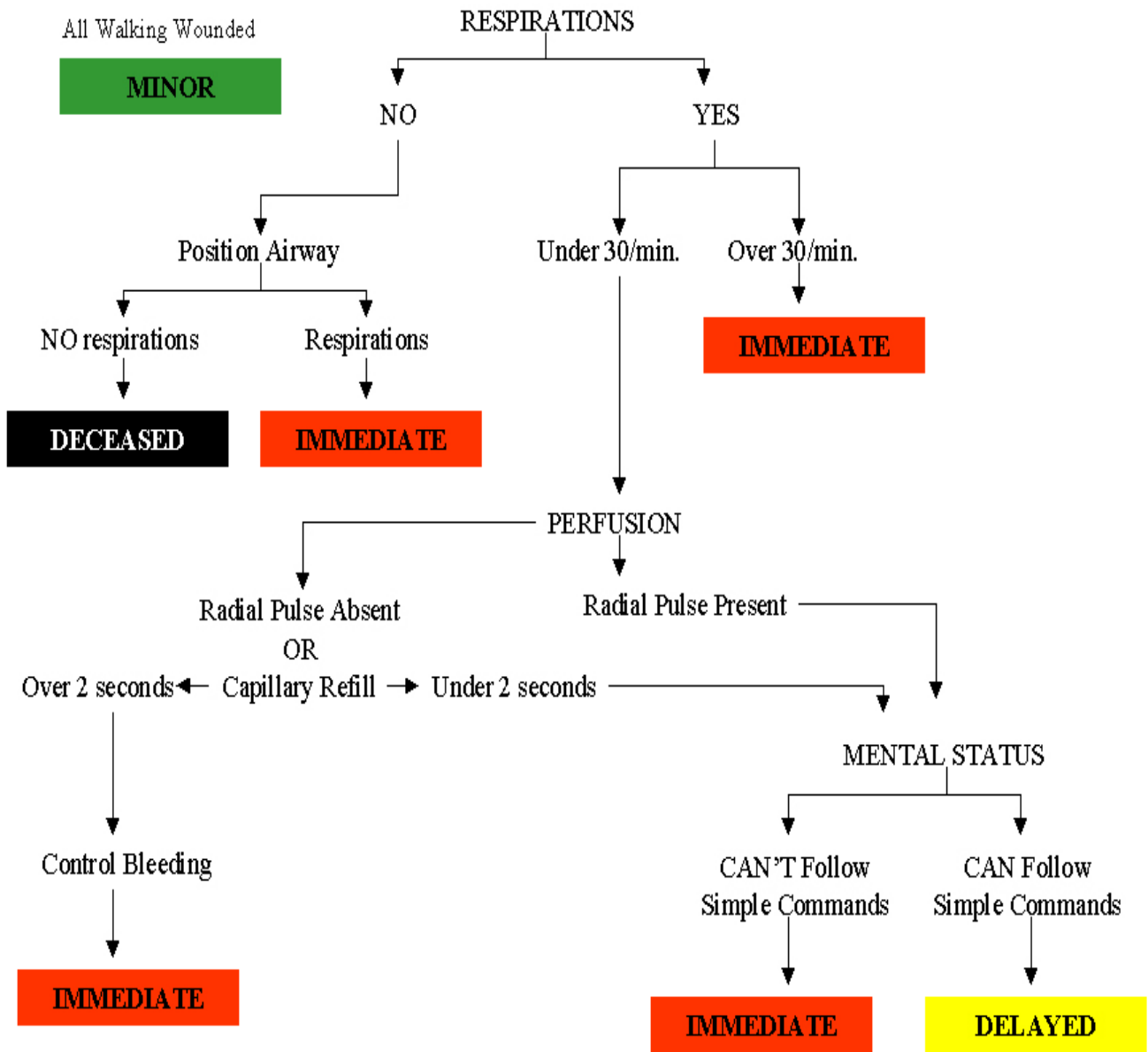
## ATTACHMENT 4.



**START** Triage - Adult

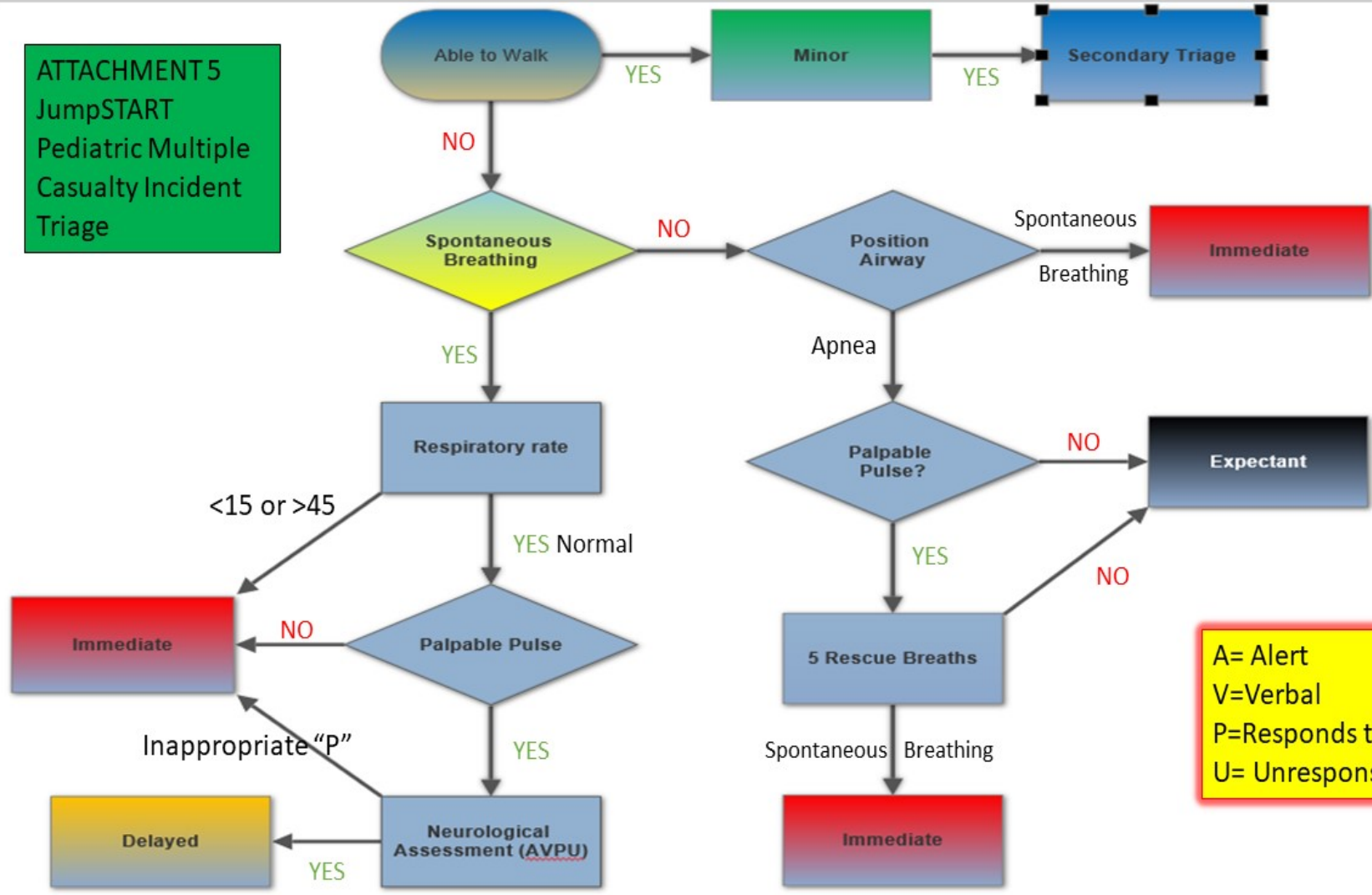
**JUMPSTART** Triage - Pediatric





<http://citmt.org/Start/default.htm>

**ATTACHMENT 5  
JumpSTART  
Pediatric Multiple  
Casualty Incident  
Triage**



A= Alert  
V=Verbal  
P=Responds to pain  
U= Unresponsive

<https://chemm.nlm.nih.gov/startpediatric.htm>

## APPENDIX A.

### Resource Challenges by Disaster Type

- Pandemic
- Chemical
- Pediatric Mass Casualty Trauma
- Burn
- Blast/Crush
- Radiological/Nuclear



[Volume 7--Appendixes | Crisis Standards of Care: A Systems Framework for Catastrophic Disaster Response: Volume 1: Introduction and CSC Framework | The National Academies Press](#)

## Pandemic – Specific Challenges

- PPE use and type required
- Vaccine, antiviral, antibiotic supply and use
- Critical care capacity
- Outpatient care capacity
- Alternate care site establishment (early treatment—flu centers, also hospital overflow)
- Mechanical ventilation capacity
- ECMO criteria and capacity

## Space /Staff/Supply Considerations

- PPE supplies, particularly N95 masks if required
- Medications including antivirals, antibiotics, analgesics, paralytics
- Outpatient care and inpatient care spaces may be insufficient and require alternate care sites
- Ventilators, ECMO supplies, and equipment and staffing plans
- Staff illness, family obligations, or reluctance to report may contribute to difficulty with adequate staffing

## Triage Issues

- Contingency plans for PPE and medication shortages
- Outpatient referral/triage plans (hotlines, phone prescribing, etc.)
- Triage criteria and process for life-saving interventions
- Triage criteria for emergency care (vs. referral to “flu center” or similar location)



<https://www.ok.gov/health2/documents/Hospital%20Crisis%20Standards%20of%20Care.pdf>

## Chemical – Specific Challenges

- Mass airway management and ventilator therapy
- Antidotal treatment (atropine, pralidoxime particularly)
- Mass decontamination

## Space /Staff/Supply Considerations

- Intubation equipment
- Antidotes (onsite and community/SNS) (SNS weblink)
- Critical care equipment
- “Dry decontamination” kits (redressing kits)
- Chemical PPE and HAZMAT training for staff

## Triage Issues

- Temporizing (bag-valve, other) therapies reasonable while awaiting outside resources.
- May still have good outcomes in cardiac arrest in organophosphate poisoning, but in mass casualty situation may have to prioritize care to those prior to respiratory arrest.



<https://www.ok.gov/health2/documents/Hospital%20Crisis%20Standards%20of%20Care.pdf>

## Pediatric Mass Casualty - Specific Challenges

- Age-specific sizes of equipment
- Airway
- intravenous access catheters
- operative equipment
- Educational background often lacking for pediatric-specific resuscitation and management

## Space /Staff/Supply Considerations

- All facilities should be prepared to stabilize and initially treat pediatric patients
- Community plan should concentrate critical patients and those 5 years or less at pediatric facilities
- Just-in-time education for staff, initial treatment resources
- Consider pediatric technical expert availability (telemedicine or telephone consult—preferably to experts outside affected area) to facilities that must manage patients out of their usual range of expertise
- Facility should plan for managing unaccompanied children (including once medically cleared) and their needs for support

## Triage Issues

- Trauma care
- Assessment may be difficult due to verbal skills and fear
- Physiologic compensation may mask “usual” signs of shock until advanced
- EMS triage procedures should emphasize keeping families together when possible



<https://www.ok.gov/health2/documents/Hospital%20Crisis%20Standards%20of%20Care.pdf>

## Trauma - Specific Challenges

- Triage bottlenecks
- Airway and initial interventions
- CT and imaging bottlenecks
- Operative bottlenecks
- Surgical and trauma supplies

## Space /Staff/Supply Considerations

- All hospitals should be prepared to manage trauma patients and stock adequate supplies per their role in the community
- Consider caching operative supplies (especially major procedure, chest tube, orthopedic trays)
- Selective use of CT and other imaging—plan and exercise

## Triage Issues

- Basic trauma triage, including knowledge of impact of GCS, age, and multisystem trauma on prognosis
- Provide palliative care to those who cannot be offered definitive interventions
- The larger the event, the higher the concentration on targeted, brief interventions with high impact (hemorrhage control, pneumothorax decompression, airway management)



<https://www.ok.gov/health2/documents/Hospital%20Crisis%20Standards%20of%20Care.pdf>



## Burn- Specific Challenges

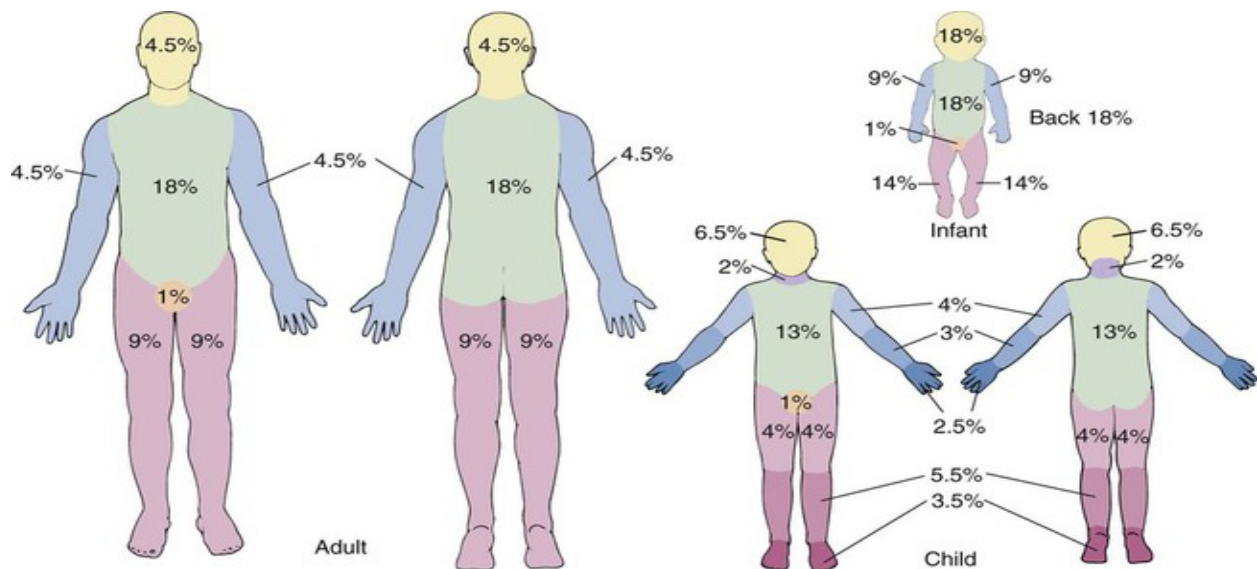
- Lack of burn beds and burn centers
- Educational background often lacking for burn resuscitation and management
- Intravenous fluids, dressings, and analgesics limited
- Limited number of burn surgeons and nurses

## Space /Staff/Supply Considerations

- Burn centers should stock supplies for large-scale burn incidents, including adequate analgesia
- All facilities should be prepared to stabilize and initially treat burn patients
- Community plan should concentrate critical burns at burn centers (may involve redistributing other patient groups)
- Just-in-time education for staff
- Consider burn technical expert availability (telemedicine or telephone consult—consider experts from another unaffected area) to facilities that must manage patients out of their usual range of expertise

## Triage Issues

- Use knowledge of contributing injuries, inhalational injury, age, and extent of burns when triaging burn patients
- Provide palliative care to those who cannot be offered definitive interventions
- Provide temporizing measures such as escharotomy and airway management while deferring formal burn dressings initially in favor of sterile sheets and towels



<https://www.ok.gov/health2/documents/Hospital%20Crisis%20Standards%20of%20Care.pdf>

## Blast/Crush - Specific Challenges

### Triage

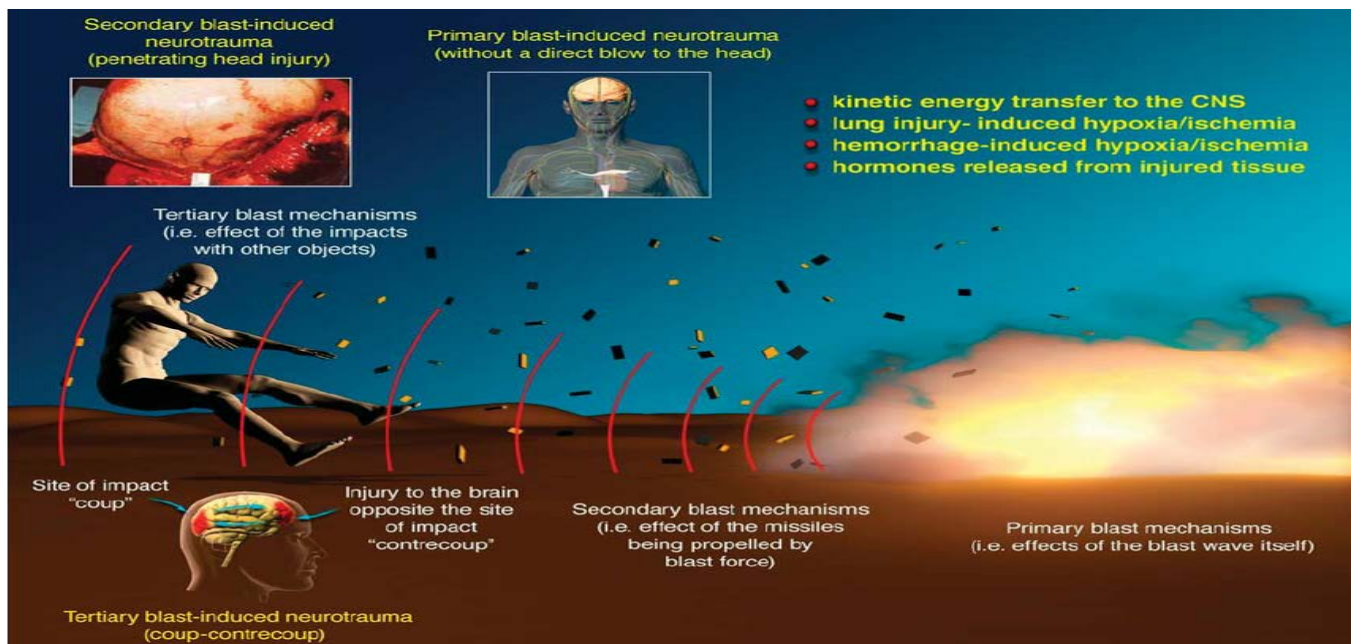
- Education on blast/crush injuries may be lacking
- Intravenous fluids and medications may be limited
- Surgical bottlenecks
- Dialysis capacity may be challenged, especially if infrastructure damaged in community

### Space /Staff/Supply Considerations

- Cache common medications (sodium bicarbonate, narcotic analgesia, antibiotics) needed for blast/crush injuries
- Cache equipment such as tourniquets, major procedure trays, external fixators and ortho trays, additional suture trays ocular trays, ENT trays
- Just-in-time education on crush injury and other specific syndromes
- Activate necessary community (and national, if needed) dialysis capacity for event

### Triage Issues

- Triage based on knowledge of injuries, contributing underlying disease and age—for blast injuries multiple extremity
- Injuries and low GCS are correlated with poor outcomes
- Assess carefully for subtle penetrating injury and compartment syndrome
- Provide temporizing treatments such as hemorrhage control (including tourniquets with blast injuries, multiple extremities



<https://www.ok.gov/health2/documents/Hospital%20Crisis%20Standards%20of%20Care.pdf>

## Nuclear - Specific Challenges

- Overwhelming acute trauma for hospitals near incident
- Overwhelming numbers of acute radiation syndrome (ARS) casualties in subsequent days/weeks
- Identification/ categorization of ARS casualties—difficulty accessing lab testing or results
- Shortages of cytokines and blood products (especially platelets during bone marrow failure phase)
- Large number of expectant patients from initial trauma, radiation, or combined injury

## Space /Staff/Supply Considerations

- Plan with community per hazard vulnerability for overall response, including evacuation of patients in latent phase of ARS to other jurisdictions with intact infrastructure
- Identify areas for alternate ambulatory triage sites
- Identify equipment for triage areas (tourniquets, bandages early, later antiemetic and antidiarrheal)
- Identify sources of radiation illness information, cytokines, other supplies

## Triage Issues

- Triage for injured is per usual trauma priorities
- Vomiting in early hours is non-specific and can be due to many causes
- Use of Absolute Lymphocyte Count (ALC) is optimal for assessment of ARS, but may not be easily available
- Victim information (proximity, particulate debris) and symptoms can allow rough classification within a few days after the event
- All forms of triage likely to be needed with more proactive processes and guidance the farther out from the event both temporally and geographical

## Phases of Radiation Injury

Dose (Gy)	Prodromal Phase	Manifest Phase	Prognosis without Supportive Care
0.5–1.0	Mild	Modest decline in blood counts	Survival
1.0–2.0	Mild–moderate	Some bone marrow damage	Survival >90%
2.0–3.5	Moderate	Moderate–severe bone marrow damage	Probable survival
3.5–5.5	Severe	Severe bone marrow damage; modest GI damage	Death within 3.5–6 wk (50% of victims)
5.5–7.5	Severe	Pancytopenia and moderate GI damage	Death probable within 2–3 wk
7.5–10.0	Severe	Severe GI and bone marrow damage	Death probable within 2 wk
10	Severe	Severe GI damage, radiation-induced lung injury, altered mental status; at higher doses (>20.0 Gy), cardiovascular collapse, fever, shock	Death within 2 wk

*Ann Intern Med. 2004;140:1037–1051.*

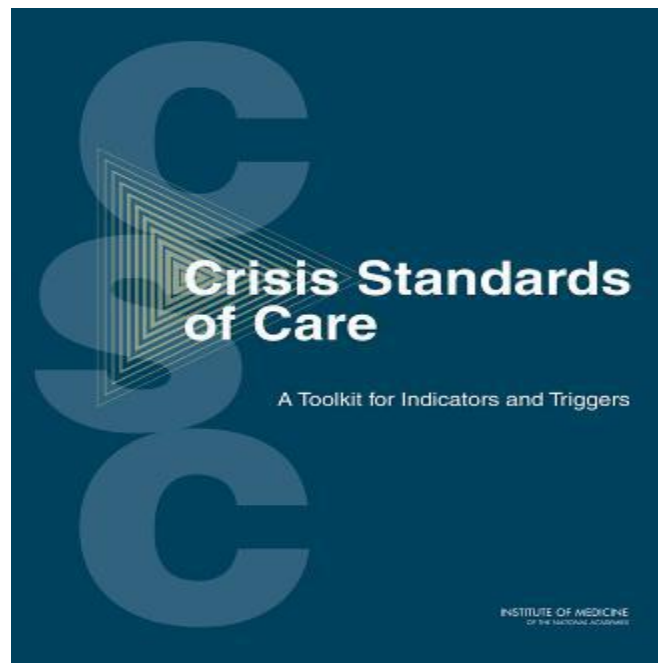
<https://www.ok.gov/health2/documents/Hospital%20Crisis%20Standards%20of%20Care.pdf>

## Appendix B

# Hospital Indicators, Triggers, and Tactics for Transitions along the Continuum of Care



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<http://www.nationalacademies.org/hmd/~media/Files/Report%20Files/2013/CSC-Triggers/HospitalandAcuteCareToolkit.pdf>

## Community and Communications Infrastructure

Contingency	Crisis	Return to Conventional
<p><b><u>Indicators</u></b> Impact on community, including transportation and communications infrastructure</p>	<p><b><u>Indicators</u></b> Community-wide and likely prolonged impact on infrastructure affecting employee homes, transportation, and communication</p>	<p><b><u>Indicators</u></b> Restoration of services and transportation access</p>
<p><b><u>Triggers</u></b> Loss of paging and/or cellular service in area</p> <ul style="list-style-type: none"> <li>• Loss of phone service to hospital</li> <li>• Loss of electrical service to hospital</li> <li>• Closure of transit system</li> </ul>	<p><b><u>Triggers</u></b> Loss of electrical power or generator failure</p>	<p><b><u>Triggers</u></b> Restored electrical service</p>
<p><b><u>Tactics</u></b> Use alternate communications strategies such as mass media and text messages, 700 or 800 MHz radio, satellite phones, HAM radios</p> <ul style="list-style-type: none"> <li>• Provide employee alternate transportation options and onsite temporary housing</li> <li>• Provide information to staff, visitors, and family members about impacts and response actions/options</li> </ul>	<p><b><u>Tactics</u></b> Hospital evacuation/diversion if possible</p> <ul style="list-style-type: none"> <li>• Consider whether shelter-in-place is an option</li> <li>• Provide bag-valve ventilation for ventilator-dependent patients or place on battery-operated transport ventilators</li> <li>• Anticipate need to switch to gravity drip IV medications with monitoring of drip rates as pump batteries fail</li> </ul>	<p><b><u>Tactics</u></b> Scale back tactics or revert to conventional operations</p>

## Surveillance Data

Contingency	Crisis	Return to Conventional
<p><b><u>Indicators</u></b>            Pandemic or epidemic (e.g., SARS) virus detected</p> <ul style="list-style-type: none"> <li>• Health alert or other notification received</li> <li>• Natural disaster occurs or mass casualty incident (MCI) declaration in community</li> <li>• Epidemiologic forecasts (Centers for Disease Control and Prevention [CDC], etc.)</li> <li>• Local surveillance/epidemiology data</li> <li>• Standard metrics such as NEDOCS (National Emergency Department Overcrowding Score)</li> <li>• Regional/community emergency department (ED) volume, ED wait times/boarding times</li> <li>• Regional/community hospital capacity or subset data, such as available intensive care unit (ICU) beds</li> </ul>	<p><b><u>Indicators</u></b>            Epidemiologic projections will exceed resources available</p>	<p><b><u>Indicators</u></b>            Surveillance streams show decline in activity</p> <ul style="list-style-type: none"> <li>• Improvement in regional/community ED volumes/wait times/boarding times</li> </ul>
<p><b><u>Triggers</u></b>            Receipt of health alert triggers group notification by receiving infection prevention personnel</p> <ul style="list-style-type: none"> <li>• Disaster plan activated when &gt;X seriously injured victims expected at facility—Hospital Command Center opens</li> <li>• “Full capacity” plan initiated when ED wait times exceed X hours</li> </ul>	<p><b><u>Triggers</u></b>            Epidemiology projections exceed surge capacity of facility for space or specific capability (e.g., critical care)—see below space and supply considerations as triggers should be based on depletion of available resources</p>	<p><b><u>Triggers</u></b>            Not specified for predictive data, will adjust based on specific actionable data</p>
<p><b><u>Tactics</u></b>            Change or increase monitoring parameters, additional situational awareness activities</p> <ul style="list-style-type: none"> <li>• Partial or full activation of incident command system/hospital command center</li> <li>• Communication/coordination with stakeholders/coalition partners</li> <li>• Change hours, staffing, internal processes in accord with facility plans</li> <li>• Assess predicted impact on institution</li> </ul>	<p><b><u>Tactics</u></b></p>	<p><b><u>Tactics</u></b>            Stand down incident management (scaled)</p> <ul style="list-style-type: none"> <li>• Lengthen duration of planning cycles</li> <li>• Reduce/deactivate regional information exchange</li> <li>• Facility practices revert toward conventional</li> <li>• Revert to normal system monitoring (defer this until incident clearly concludes)</li> </ul>



## Staff

Contingency	Crisis	Return to Conventional
<p><b><u>Indicators</u></b></p> <ul style="list-style-type: none"> <li>• Increasing staff absenteeism</li> <li>• Specialized staff needed (pediatrics, burn, geriatrics) for incident patients</li> <li>• School closures</li> <li>• Staff work action anticipated (e.g., strike)</li> <li>• High patient census</li> <li>• Staffing hours adjustment required to maintain coverage</li> <li>• Staffing supervision model changes required to maintain coverage</li> </ul>	<p><b><u>Indicators</u></b></p> <p>Increasing staff requirements in face of increasing demand</p> <ul style="list-style-type: none"> <li>• Contingency spaces maximized</li> <li>• Contingency staffing maximized</li> </ul>	<p><b><u>Indicators</u></b></p> <ul style="list-style-type: none"> <li>• Staff impact is reduced, schools back in session, damage to community mitigated</li> <li>• Staff absenteeism reduced</li> <li>• Specialty staff obtained, or demand decreased</li> </ul>
<p><b><u>Triggers</u></b></p> <p>X% staff ill call rate prompts notification of emergency management group</p> <ul style="list-style-type: none"> <li>• School closures across area trigger opening of staff day care</li> <li>• Normal staff to patient ratios exceeded</li> <li>• Specific staff expertise demands exceeded (e.g., mass burn event – depletion of burn nurses)</li> </ul>	<p><b><u>Triggers</u></b></p> <p>Unable to safely increase staff to patient ratios or broaden supervisory responsibilities</p> <ul style="list-style-type: none"> <li>• Lack of qualified staff for specific cares—especially those with high life-safety impact</li> </ul>	<p><b><u>Triggers</u></b></p> <p>Staff to patient ratios of 1:X achieved on medical floor</p>
<p><b><u>Tactics</u></b></p> <p>Assess likely impact on facility</p> <ul style="list-style-type: none"> <li>• Hold staff</li> <li>• Change hours, staffing patterns</li> <li>• Change staff to patient ratios</li> <li>• Specialty staff provide only specialty/ technical care, while other staff provide more general care</li> <li>• Callback, obtain equivalent staff from coalition, hiring, administrative staff</li> <li>• Change charting responsibilities</li> <li>• Curtail non-essential staffing (cancel elective cases, specialty clinic visits, etc.)</li> <li>• Provide support for staff (and their families as required) to help them continue to work and provide quality care (e.g., stress “immunization,” rest periods, housing support)</li> </ul>	<p><b><u>Tactics</u></b></p> <p>Tailor responsibilities to expertise, diverting non-technical or non-essential care to others</p> <ul style="list-style-type: none"> <li>• Recruit and credential staff from volunteer (Medical Reserve Corps [MRC], Emergency System for Advance Registration of Volunteer Health Professionals [ESAR-VHP]) or federal sources (Disaster Medical Assistance Team [DMAT], other National Disaster Medical System [NDMS] source, etc.)</li> </ul> <p>Establish remote consultation of specialized services such as telemedicine, phone triage, etc., if possible</p> <ul style="list-style-type: none"> <li>• Evacuate patients to other facilities with appropriate staff available</li> </ul>	<p><b><u>Tactics</u></b></p> <p>Shorten shift lengths</p> <ul style="list-style-type: none"> <li>• Adjust staff to patient ratios toward normal</li> <li>• Transition toward usual staff – releasing less qualified staff first</li> <li>• Resume care routines</li> <li>• Resume administrative duties</li> </ul>



## Space/Infrastructure

Contingency	Crisis	Return to Conventional
<p><b><u>Indicators</u></b></p> <ul style="list-style-type: none"> <li>• Increased ED volumes</li> <li>• Increased clinic/outpatient volumes</li> <li>• Increased inpatient census</li> <li>• Increased pending admits/ED boarding</li> </ul>	<p><b><u>Indicators</u></b></p> <p>Inpatient/outpatient contingency spaces maximized or near-maximized</p> <ul style="list-style-type: none"> <li>• Escalating or sustained demand on ED/outpatient despite implementing contingency strategies</li> <li>• Damage to infrastructure affecting critical systems</li> </ul>	<p><b><u>Indicators</u></b></p> <ul style="list-style-type: none"> <li>• Favorable epidemiologic curves</li> <li>• Restoration of critical system function</li> <li>• ED/outpatient volumes decreasing</li> </ul>
<p><b><u>Triggers</u></b></p> <ul style="list-style-type: none"> <li>• Inpatient census exceeds conventional beds</li> <li>• Damage to infrastructure</li> <li>• Clinics unable to accommodate demand for acute care</li> <li>• &gt;X hours ED boarding time</li> <li>• Electronic health record downtime</li> <li>• Telephone or internet systems failures</li> </ul>	<p><b><u>Triggers</u></b></p> <ul style="list-style-type: none"> <li>• Contingency inpatient beds maximized (may include subset of ICU, burn, pediatrics, etc.)</li> <li>• Contingency outpatient adaptations inadequate to meet demand using equivalent spaces or strategies</li> <li>• Damage to infrastructure affecting critical systems and presenting a safety issue to staff/patients</li> </ul>	<p><b><u>Triggers</u></b></p> <ul style="list-style-type: none"> <li>• Patients able to be matched to appropriate areas for care</li> </ul>
<p><b><u>Tactics</u></b></p> <ul style="list-style-type: none"> <li>• Expand hours of outpatient care</li> <li>• Open additional outpatient care space by adjusting specialty clinic space/times</li> <li>• Provide “inpatient” care on Pre-induction, post anesthesia care, other equivalent areas</li> <li>• Divert patients to clinics/other facilities</li> <li>• Transfer patients to other facilities</li> <li>• “Reverse triage” appropriate patients home (with appropriate homecare)</li> <li>• Implement downtime procedures for IT systems</li> </ul>	<p><b><u>Tactics</u></b></p> <p>Establish non-traditional alternate care locations (e.g., auditorium, tents, conference rooms), recognizing governmental role in authorizing waivers</p> <ul style="list-style-type: none"> <li>• “Reverse triage” stable patients to these areas move stable ICU patients to monitored bed areas (i.e., step-down units deliver ICU-level care)</li> </ul> <p>Consider other methods of outpatient care, including telephone treatment and prescribing</p> <ul style="list-style-type: none"> <li>• Change admission criteria – manage as outpatients with support/early follow-up</li> <li>• Evacuate patients to other facilities in the region/state/nation that have appropriate capabilities and capacity</li> </ul>	<p><b><u>Tactics</u></b></p> <p>Transitional movement of sickest patients back into ICU environment</p> <ul style="list-style-type: none"> <li>• Broaden admission criteria</li> <li>• Reduce/eliminate care in non-traditional spaces (stop providing assessment/care in non-patient care areas/cot-based)</li> <li>• Shift toward normal hours</li> </ul>

## Supplies

Contingency	Crisis	Return to Conventional
<p><b><u>Indicators</u></b>            Vendor supply or delivery disruption</p> <ul style="list-style-type: none"> <li>• Supply consumption/use rates</li> <li>• Epidemiology of event predicts supply impact</li> </ul>	<p><b><u>Indicators</u></b>            Coalition lack of available ventilators</p> <ul style="list-style-type: none"> <li>• Anesthesia machines and other adaptive ventilation strategies in use</li> <li>• Coalition/vendor lack of available critical supplies/medications</li> </ul>	<p><b><u>Indicators</u></b></p> <ul style="list-style-type: none"> <li>• Reduced use of PPE or other supplies</li> <li>• Reduced caseload or demand for care and services</li> <li>• Improved delivery of supplies</li> <li>• Reduced need for ventilator or other triage</li> </ul>
<p><b><u>Triggers</u></b>            Event epidemiology predicts ventilator or other specific resource shortages (e.g., pediatric equipment)</p> <ul style="list-style-type: none"> <li>• Medication/vaccine supply limited</li> <li>• Consumption rates of personal protective equipment (PPE) unsustainable</li> <li>• Vendor shortages impact ability to provide normal resources</li> </ul>	<p><b><u>Triggers</u></b></p> <ul style="list-style-type: none"> <li>• Inadequate ventilators (or other life-sustaining technology) for all patients that require them</li> <li>• Inadequate supplies of medications or supplies that cannot be effectively conserved or substituted for without risk of disability or death without treatment</li> </ul>	<p><b><u>Triggers</u></b>            Able to provide contingency ventilation and critical care strategies to all that require them</p>
<p><b><u>Tactics</u></b>            Use non-traditional vendors</p> <ul style="list-style-type: none"> <li>• Obtain from coalition facilities/stockpiles (including potential state/federal sources)</li> <li>• Conserve, substitute, or adapt functionally equivalent resources; reuse if appropriate</li> </ul>	<p><b><u>Tactics</u></b>            Implement triage team/clinical care committee process</p> <ul style="list-style-type: none"> <li>• Determine bridging therapies (bag-valve ventilation, etc.)</li> <li>• Coordinate care /triage policies with coalition facilities (in no-notice event, this may not be possible)</li> <li>• Triage access to life-saving resources (ventilators, blood products, specific medications) and reallocate as required to meet demand according to state/regional consensus recommendations.</li> <li>• Restrict medications to select indications</li> <li>• Restrict PPE to high-risk exposures (and/or permit PPE reuse)</li> <li>• Reuse or reallocate resources when possible (benefit should outweigh risks of reuse; reallocate only when no alternatives – see criteria in IOM, 2012)</li> </ul>	<p><b><u>Tactics</u></b>            Re-triage patients as resources become available</p> <ul style="list-style-type: none"> <li>• Broaden indications for interventions as conditions improve</li> <li>• Transition back from reallocation and reuse to safer adaptive and conservation strategies</li> <li>• Loosen restrictions on use of supplies</li> </ul>

## APPENDIX C – TERMS and ACRONYMS

Acronyms	Expanded
AFN	Access and Functional Needs
AHRQ	Agency for Healthcare Research and Quality
ARCH-P	
ASPR	Assistant Secretary for Preparedness and Response
AVPU	Alert, Verbal, Pain, Unresponsive
BHEM	Bureau of Health Emergency Management
CBRNE	Chemical, Biological, Radiological, Nuclear, Explosive
CCC	Critical Care Committee
CDC	Center for Disease Control and Prevention
CFDA	Catalog of Federal Domestic Assistance
CFR	Code of Federal Regulations
CISM	Critical Incident Stress Management
C-MIST	Communication, Medical Care, Independence, Supervision, Transportation
CMJ	Cambridge Medical Journal
CMS	Centers for Medicare and Medicaid Services
CSC	Crisis Standards of Care
CT	Computerized Tomographic
DMORT	Disaster Mortuary Operational Response Team

DOC	Department Operations Center
DOH	Department of Health
DSLRL	Division of State and Local Readiness
ECMO	Extracorporeal membrane oxygenation
ED	Emergency Department
EMS	Emergency Medical Services
EMTALA	Emergency Medical Treatment and Labor Act
EOC	Emergency Operations Center
EOP	Emergency Operations Plan
ERD	Epidemiology and Response Division
ESF	Emergency Support Function
FEMA	Federal Emergency Management Agency
FMS	Federal Medical Station
FQHC	Federally Qualified Health Clinics
GCS	Glasgow Coma Scale
HAZMAT	Hazardous Materials
HCC	Healthcare Coalition
HHS	Health and Human Services
HICS	Hospital Incident Command System
HPP	Hospital Preparedness Program
HRS	Hospital Reception Site

HSD	Human Services Department
IC	Incident Commander
ICS	Incident Command System
ICU	Intensive Care Unit
IOM	Institute of Medicine
JIC	Joint Information center
JIS	Joint Information System
LSI	Life Saving Interventions
MAT	Medical Advisory Team
MCM	Medical Counter Measures
MIST	Medical Care, Independence, Supervision, Transportation
MOA	Memorandum of Agreement
MOU	Memorandum of Understanding
MRC	Medical Reserve Corps
NDMS	National Disaster Medical System
NHPP	National Healthcare Preparedness Program
NMBN	New Mexico Board of Nursing
NMDOH	New Mexico Department of Health
NMSA	New Mexico State Authority
OPEO	Office of Preparedness and Emergency Operations
OR	Operating Room

PA	Physician's Assistant
PACU	Pre-anesthesia Care Unit
PHEP	Public Health Emergency Preparedness
PIO	Public Information Officer
PPE	Personal Protective Equipment
PSAP	Public Safety Answering Points
RN	Registered Nurse
SALT	Sort, Assess, Lifesaving Intervention, Treatment/Transport
SBP	Systolic Blood Pressure
SME	Subject Matter Expert
SMI	Serious Mental Illness
SNS	Strategic National Stockpile
SOFA	Sequential Organ Failure Assessment
SOG	Standard Operating Guidelines
START	Simple Triage and Rapid Treatment

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